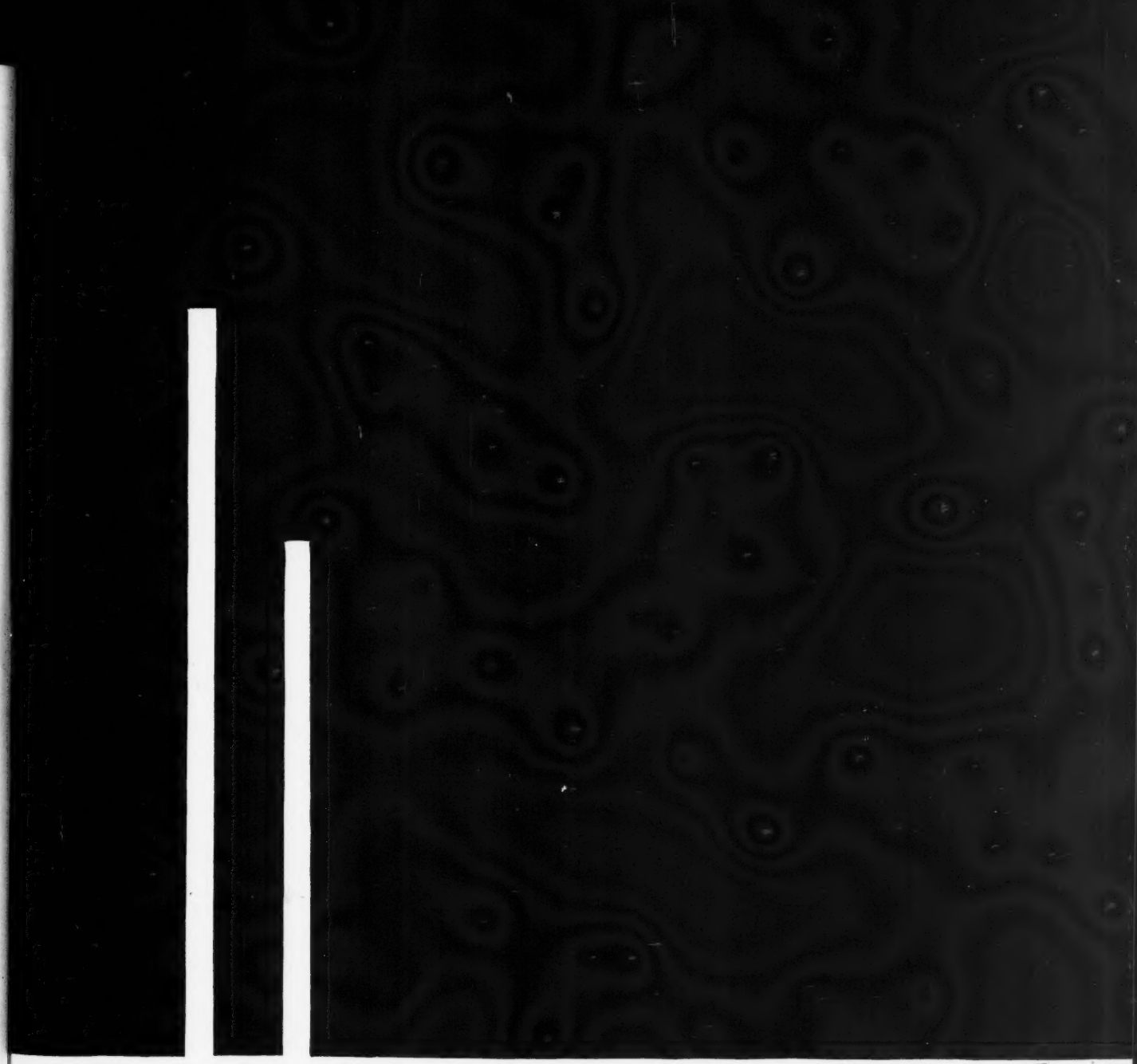

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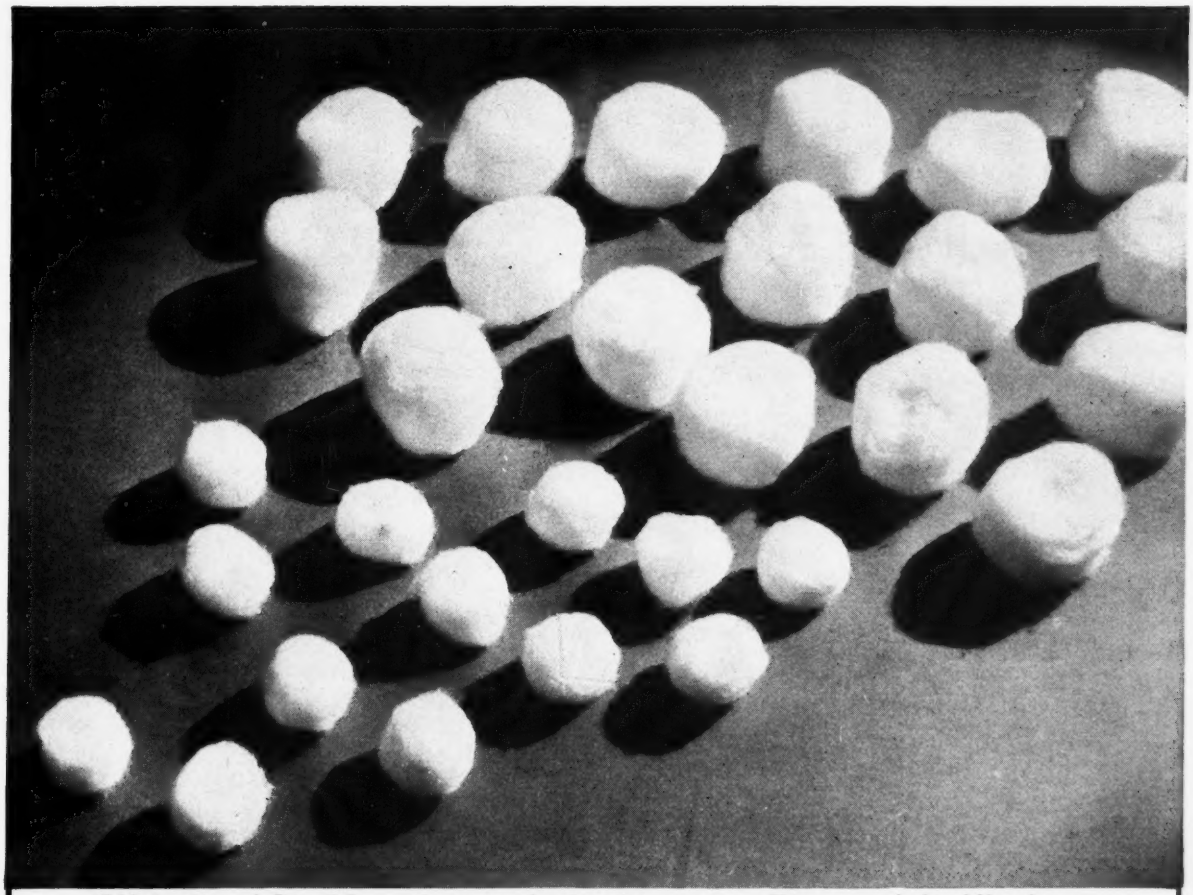

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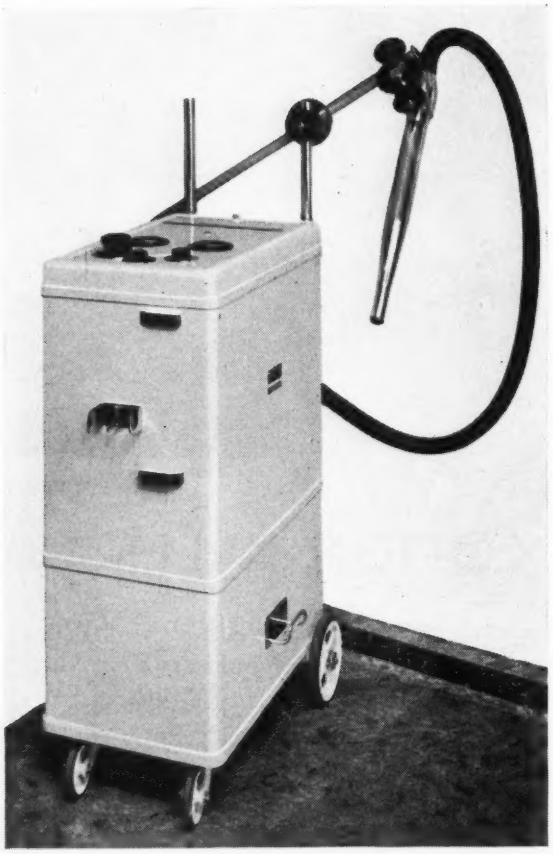

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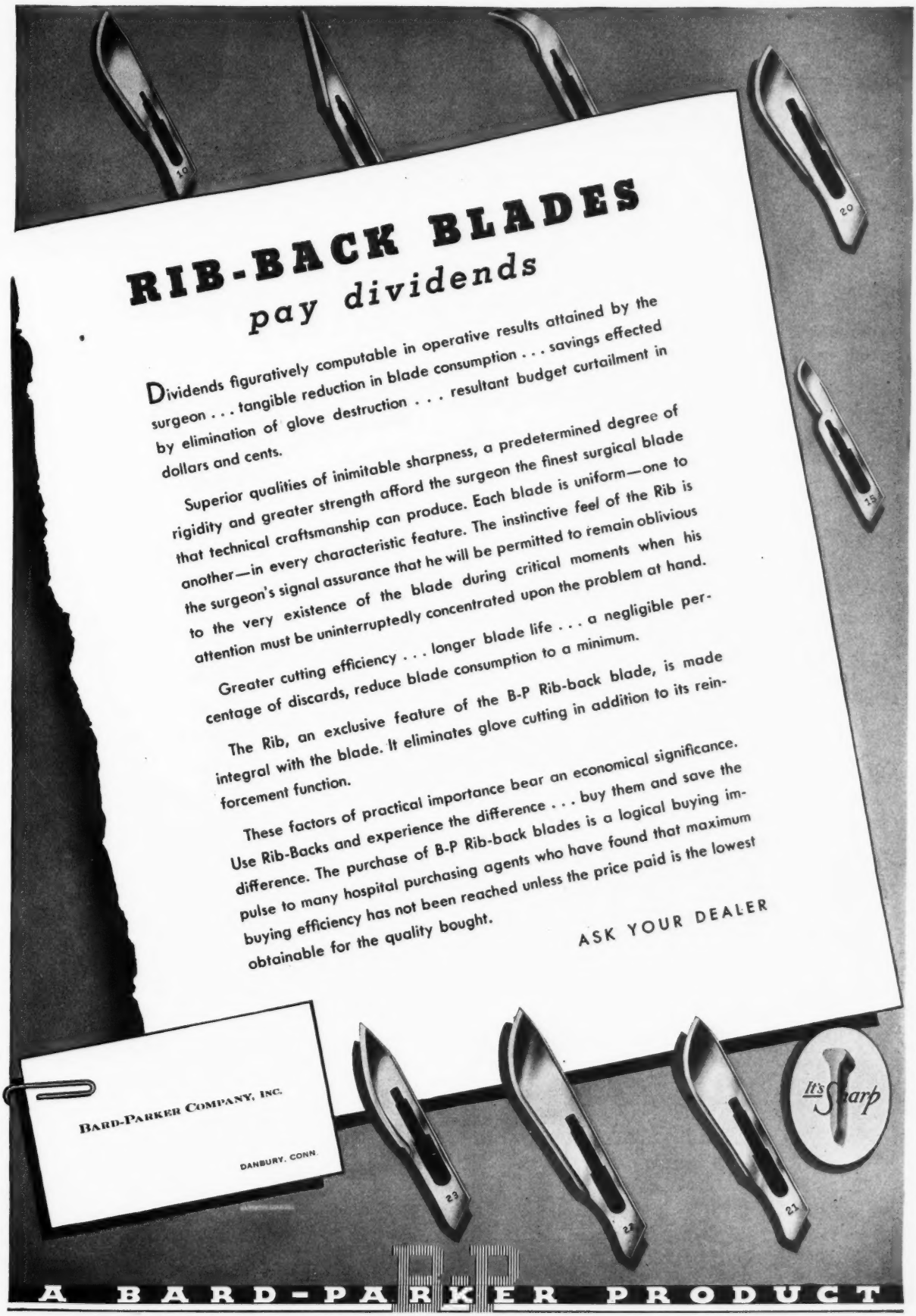
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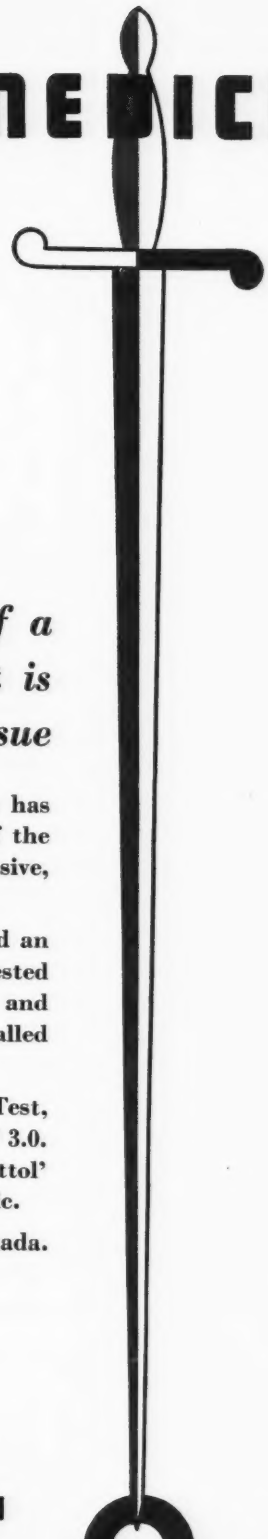

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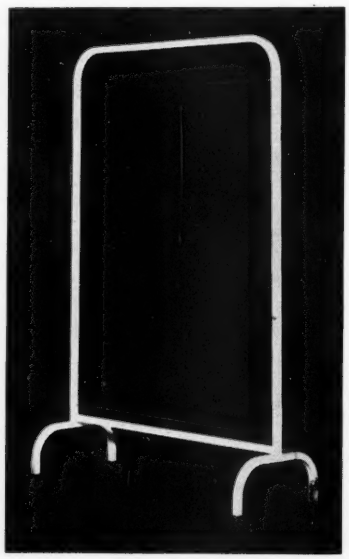

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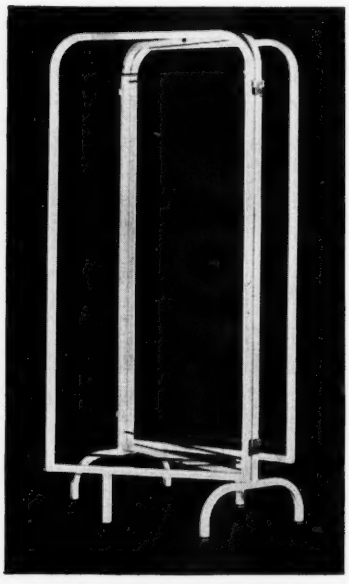

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We wish to state here that *no preservatives are used in commercially canned foods.*

Spoilage of food is principally caused by the growth and multiplication in food of microorganisms such as yeasts, molds, or certain types of bacteria. These microorganisms depend upon the food they inhabit for their nutrition and their life processes produce changes in the chemical or physical characteristics of food, or both. These changes lead us to state that the food has "spoiled".

Like other living organisms, these spoilage microorganisms can grow and multiply in a food only as long as conditions remain favourable for their existence. If any environmental factor, such as temperature, moisture or acidity, becomes unfavourable, these spoilage organisms are destroyed, or their development is inhibited.

All methods of food preservation have a common underlying principle; they all alter some factor or factors in the food environment so as to render conditions unfavourable for the growth or development of spoilage organisms in the food.

Thus, foods may be preserved by freezing or refrigeration, which serves to lower the temperature below that optimum for growth of certain spoilage organisms; dried foods keep because the moisture content has been reduced to an unfavourably low level; certain fermented foods keep because of the development of high acidity. All of these methods produce changes in the environment in which the food spoilage organisms must live.

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The hermetic seal insures protection against future infection of the food by such organisms.

Thus, commercial canning is a method of food preservation which has for its basis the thermal destruction of spoilage organisms; no chemical preservatives are needed to insure preservation of the foods, and, consequently, none are used.

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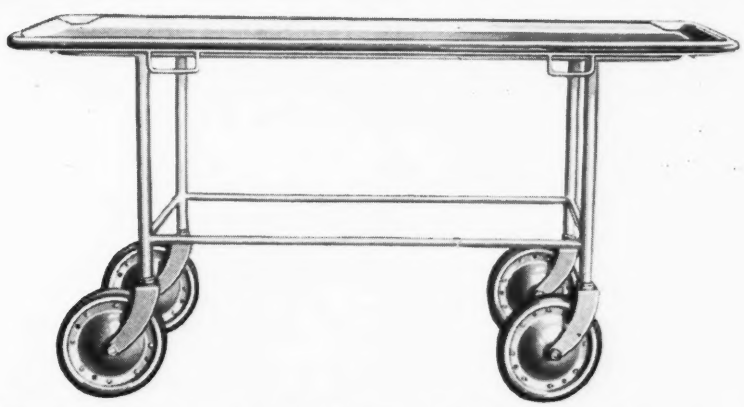

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The CANADIAN HOSPITAL

MAY, 1938 Vol. 15 No. 5

SWEEPSTAKES FOR HOSPITALS

THE recent action of the Ontario Legislature in supporting, by a majority vote, the principle of sweepstakes revives again a controversy which seems to crop up at ever-recurring intervals. While this vote carries no legislative authority, as the legislation of sweepstakes is under federal jurisdiction, the attendant publicity is certain to arouse nation-wide interest. Naturally, as the hospitals are almost invariably named in any advocacy of sweepstakes, the hospitals are vitally concerned with this question. Because of the far reaching effect of any such legislation, hospital workers should be fully cognizant of the many factors involved.

The Affirmative

There is much to be said in favour of the proposal:

(1) A considerable sum of money leaves the country each year to benefit citizens in a foreign country and it is rightly asked, Why can we not keep that money in Canada?

(2) Hospitals in Ireland which were in financial straits have profited greatly by these lotteries. Much expansion and improvement have been possible since the inauguration of sweepstakes.

(3) Most people will gamble no matter what legal restrictions are set up. Why not legalize the custom?

(4) The effect of lotteries on the moral fibre of the people is questioned. Lotteries are now carried on under various guises—raffles, the stock market, pari mutuel betting, etc. The principle is followed by various church organizations now.

(5) With increasing demands from the public for state assistance or subsidy for this or that, municipal and provincial authorities are having considerable difficulty in devising new methods of raising money. If certain accepted responsibilities such as the payments to hospitals of indigent care could be financed by this additional and indirect source of revenue, it is obvious that Treasury funds to that extent would be liberated for other purposes and political prestige enhanced. For this reason the sweepstake method of financing hospitals has a strong appeal to the legislator and the municipal councillor and would explain the interest of legislative and municipal bodies in this proposal.

The Negative

There is, however, another side to this question. Sweepstakes are by no means a new idea and their history has not been a particularly happy one. Their moral value has never been championed. Nor, as has been well expressed, do illusive dreams of wealth inspired by cupidity make for a stable economic state.

The present agitation for sweepstakes is for the asserted purpose of helping the hospitals. Actually hospital workers as a group are afraid of the possible consequences, and for valid reasons:

(1) Private philanthropy and charity have been seriously impaired, if not almost entirely killed when large lotteries have been fostered. Moreover, government support is usually lacking or minimized in such instances. Hospitals are so dependent upon charity and philanthropy both for capital and for maintenance expenditures that those responsible dare not risk the loss or alienation of this essential support. This has been one of the main reasons for the opposition of the British hospitals to lotteries.

The Irish Hospitals Commission in its report points out that voluntary subscriptions and donations have been "very seriously diminished" and adds that, "the number of people demanding free treatment has increased considerably". Were such a notoriously unstable source of revenue withdrawn, the hospitals and their sick would be in a serious plight. This must always be kept in mind for, as was pointed out by the Royal Commission on Lotteries

This article has been approved unanimously by both the Executive Committee of the Canadian Hospital Council and the Editorial Board of The Canadian Hospital.

and Betting in its report to the British Government, "Experience shows that interest in lotteries is essentially ephemeral in character" (Section 485).

(2) A lottery is an exceedingly wasteful way of raising money. The Irish hospitals receive but approximately one fifth (20 per cent) of the money raised. If we include the amount lost on bogus and fraudulent tickets, of which the hospitals get nothing, the net percentage is still lower.

(3) It would be quite impossible to finance our hospitals by a sweepstake. The maintenance cost of our hospitals, excluding capital expenditures, according to the last available Dominion Bureau of Statistics figures, were:

Non-mental hospitals	$41,405,868
Mental institutions	10,484,937
Total Annual Maintenance	$51,890,805
Contributed by patients	21,197,612
Balance from other sources	$30,693,193

While some of this balance comes from non-governmental sources, most of it is made up of the governmental and municipal share of hospital support. To meet this amount of thirty millions of dollars, the annual amount required from the public on the basis of the Irish sweepstakes would be $150,000,000! Were the full cost of maintenance to be met, as vaguely anticipated by many, the total amount required would be still higher—and still more absurd.

The Irish Commission has received applications for grants from but 73 hospitals and has the English-speaking world to draw from. Canada has some 969 hospitals, of which 608 are public, and therefore would be eligible, and would have strong competition in selling tickets because of the huge prizes elsewhere.

(4) The burden of supporting our hospitals would be shifted, to the extent of the sweepstake contributions, to those least able to afford it. This has been repeatedly observed in Ireland, in Spain and in South American countries.

(5) The huge sums alleged to go to Ireland annually would appear to be a mere fiction. Prizes constitute between 58 and 59 per cent of the amount received; therefore it is reasonable to presume that, over the years, the amount of prize money won in Canada would be approximately 58 or 59 per cent of the amount contributed. On this basis it would seem fair to estimate that the amount spent is not $100,000,000 to $200,000,000 annually, as frequently claimed, but averages around $300,000 to $400,000 only, or probably less. Undoubtedly much of this latter amount would still go abroad, had we sweepstakes here, because of the big stakes offered elsewhere.

(6) Hospital workers, too, are a bit sceptical of the sudden interest in hospital welfare of their new champions. Are the hospitals being exploited merely as a means to an end? With the legislation of lotteries, accomplished by the setting up of such a worthy objective, would the next move be to so extend the nature of the beneficiaries that, finally, a very small share only, if any, of the proceeds would be permitted to go to the hospitals? Meanwhile they would have lost the philanthropic support of the people and possibly the aid of the municipal and provincial governments.

Why not endeavour to levy this voluntary tax for some other purpose, or to augment general revenue, if that be desirable? If the sweepstake method of raising public funds be considered sound for hospital finance, it should be equally sound for the financing of other public obligations. Why is it necessary to masquerade under the mantle of charity?

(7) Subscribers would not be so sure of winning "next time" were they to know how slim are their chances. In the last sweep on the Grand National steeplechase (March, 1938) it is reported that there were but 1774 winners among 5,492,004 ticket holders. In other words, 5,490,230 ticket holders lost! Or only one in 3095 won!

Conclusions

Admitting that something can be said in favour of sweepstakes, the concensus of hospital opinion, as we have been able to sense it, is strongly *against* sweepstakes. The Canadian Hospital Council, which officially represents all of the thirteen provincial and other hospital associations in Canada, went on record in its Winnipeg meeting in 1933 as being opposed to the principle of financing hospitals by the sweepstake method. Its executive committee, meeting in March, 1938, re-affirmed this position by resolving,

> "That the Canadian Hospital Council cannot support the principle of raising funds for the financial support of hospitals by means of sweepstakes".

The British Hospitals Association, although its members are the heaviest losers because of the Irish sweepstakes, has resolved,

> "That the British Hospital Association is not in favour of an amendment of the law affecting public sweepstakes which purport to be for the benefit of voluntary hospitals".

The Royal Commission on Lotteries and Betting to the British Government, after weighing all the evidence in a very broadminded report which countenanced certain smaller lotteries, concluded that "The institution of large lotteries in this country is not recommended".

Public Opinion

The statement that a majority of the people of Canada would favour sweepstakes is possibly correct. This is borne out by a vote in a western city and a press poll of the "man on the street" in an eastern centre. The reason is obvious. Few have really thought beneath the surface and have no realization of the consequences; most like to be considered as "sporting" and as being "broad" in their views. Many are concerned neither with hospitals nor lotteries, but wish us to be consistent in our moral and legal attitudes towards lotteries in various guises. In a matter like this, of such vital concern to the future of our hospitals and their patients,serious thought is required lest we also be swept away by a "snap judgment".

If Sweepstakes Be Legalized

Should the time come that sweepstakes for hospitals be legalized, it would be essential that several features be safeguarded:

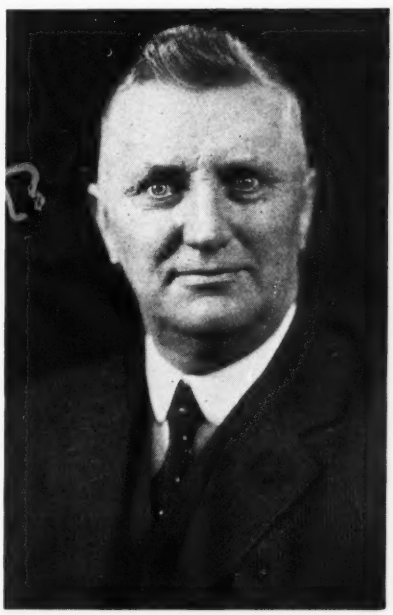
(Continued on page 18)

Periodic Payment Plan in Edmonton Based on Sound Principles

By A. F. ANDERSON, M.D., F.A.C.H.A.,
Chairman, Group Hospitalization Board, Edmonton, Alberta

IN response to numerous letters of enquiry with regard to the Edmonton Periodic Payment Plan, we present a synopsis of the general set-up of our scheme together with a summary of working results to date.

The Edmonton Plan was inaugurated and is controlled absolutely by all four general hospitals of the city, viz.: Royal Alexandra, University, Misericordia and General Hospitals. It is administered by the so-called "Group Hospitalization Board", which consists of four members, one appointee from each of these hospitals. This Board meets regularly every fortnight, passes on all applications for membership, settles all claims for hospital bills and reviews progress reports from their bonded business agent or official representative. The latter maintains a down-town office with necessary stenographic and clerical help, attends to all canvassing for membership and signing of applications, collection of dues and banking of same, together with all correspondence and other business details. He works on a commission basis. Incidentally, the total cost of operation of the plan, including said commissions, office rent, clerical assistance, printing, advertising, etc., are maintained at less than twenty-five per cent of revenue in accordance with a clause in the agreement, which the four hospitals jointly signed, covering the inauguration and conduct of said plan. All cheques are issued only over the signatures of at least two board members delegated for that purpose.



A. F. ANDERSON, M.D.,
Supt. Royal Alexandra Hospital, Edmonton.

Benefits

Benefits under the plan are limited to groups of employed persons to facilitate collections by deductions from payrolls and prevent the necessity of medical examinations. Applicants are now required to sign a declaration as to health and give information regarding any known physical ailment such as diabetes, asthma, peptic ulcer, cancer, epilepsy, hypertension, etc., both in regard to themselves and the dependents they seek to enrol. Any prospective beneficiary, known to be subject to asthma, for example, may, at the option of the board, be accepted upon the signature of the paying applicant to a waiver covering such affliction. The smallest group enrolled must have two employed paying members with at least three dependants, or five beneficiaries in all. A separate contract is signed with each employed paying member, with names and ages of all dependants enrolled on said contract. These contracts when accepted by the board are initialed by board members, as duly authorized representatives of the four hospitals concerned, whereupon hospitals seals are attached to make the contracts legal and binding. Thus the four hospitals, in effect, jointly enter into a contract with the said applicants to sell their services to the latter under certain definite terms. This rather unwieldy plan was adopted after receiving legal advice as to the necessity of avoiding infringement of the Insurance Act, etc. All contracts are for one year, providing for continuation indefinitely thereafter, until cancelled by one month's notice from either of the contracting parties. No benefits ensue for the first thirty days after the signing of a contract, but continue thirty days after termination of same. The contract may be terminated summarily by death, removal from the city, loss of employment, unless otherwise arranged by prepayment of dues, non-payment of dues, etc.

Benefits include hospitalization up to thirty days in one year in public wards, when such hospitalization is deemed by an attending physician as being necessary or advisable. Included therein are board, nursing care, intern service, operating and case-room charges, laboratory fees, basal metabolism tests, etc. For necessary X-ray examinations and treatments, physical therapy treatments and electrocardiograms, there is a fifty per cent reduction, though payments by the board covering such are limited to thirty-five dollars in any one year. Beneficiaries desiring private or semi-private ward service are given such by paying the hospital the difference between the ordinary per diem charge for such service and two dollars and a half per diem, which is the amount the board pays the hospital for each claim, except for children under fifteen, when the amount is one dollar and fifty cents per diem.

Hospitalization for such disabilities as insanity, venereal diseases, tuberculosis, and accidents covered by the Workmen's Compensation Act does not come under the scheme. Maternity cases are covered after nine months' paid up membership. Elective operations, such as tonsillectomy,

require a three months' waiting period. Contagious and infectious diseases, such as erysipelas, scarlet fever, diphtheria, etc., ordinarily treated in an Isolation Hospital, are covered, but those subject only to modified quarantine, such as mumps, measles, whooping cough, etc., and ordinarily treated at home, are not covered, except when exceptional circumstances make hospitalization necessary.

No provision is made for out-patients other than accident cases. Thus, those requiring basal metabolism tests, stomach analyses, blood counts, X-ray examinations, or physical therapy treatments are not covered unless hospitalization be otherwise required and such tests or treatments be incidental thereto. These provisions are necessary to keep the plan solvent under existing rates, and in order to play fair with the medical profession and thus ensure its co-operation.

Rates

Rates are as follows: Sixty cents per month for a paying member, fifty cents per month for each adult dependant and twenty-five cents per month for each dependant child under fifteen years of age. Dependants include wife, parents, children and brothers and sisters residing with a paying member and entirely dependent on him. No dependant over seventy years is accepted.

Comments

The plan provides for an absolutely free choice of doctor as well as hospital, provided, of course, such doctor is on the approved staff of the hospital of choice. It is definitely set out in the contract that all payments to the medical profession for services are matters of private arrangement as between the beneficiary and his own medical attendant. After some three years' operation, there are over 6,000 beneficiaries in good standing. Total revenue amounts to about $2,500 per month. Hospital claims require from 70 to 75 per cent of the above receipts. Bank surplus accumulated to date is approximately three thousand dollars, or more than sufficient to pay one month's claims. Rates remain as fixed at the inauguration of the scheme, and would appear to be sufficient to cover the benefits offered without any great margin of safety. However, the objective is not the accumulation of large reserves or the making of money but rather the provision of a plan whereby people of moderate means are able to budget for their hospital bills. The plan does not appear to have reached its saturation point as yet inasmuch as new applications continue to outnumber cancellations by more than two to one.

While the plan was originally intended to be confined to residents of the City of Edmonton, provision has since been made to cover groups of five persons, or more, resident in *surrounding municipalities* which have joint contracts with the four city hospitals covering care of their indigent residents. In such cases a year's dues have to be paid in advance because of the inability to make provision with employers for salary deductions. Likewise, employed persons in the city, covered by some form of sickness insurance acceptable to the board, are permitted to make provision under our plan for their dependants, in which case sixty cents per month is charged for the first adult dependant instead of the ordinary fifty cent rate. This class of risk has been found by experience to be not quite so profitable as where the paying member is also included in the scheme.

Each hospital is kept supplied with a revised up-to-date card index of all beneficiaries in good standing. Each beneficiary also has a card of identification.

Points of dispute, of course, arise at times. Generally speaking, the board is more liberal in its interpretation of a contract than are most sickness and accident insurance companies. So-called "chisellers", out to get everything for nothing regardless of whether the solvency of the whole plan be imperilled by their excessive and unreasonable demands, are generally dealt with by paying their claims and then serving them with a notice of cancellation before the end of their contract year.

Western Institute for Hospital Administrators to Be Held at Palo Alto Campus, Stanford University, August 8 to 19, 1938

The program for the Western Institute of Hospital Administrators sponsored jointly by the American College of Hospital Administrators, the Association of Western Hospitals, and the Association of California Hospitals in co-operation with Stanford University has just been announced. This Institute will be held at the Stanford University Campus, Palo Alto, California, August 8-19, 1938.

Problems of fundamental importance in the hospital field will be discussed, such as, Relation of Hospitals to Public Health and Medical Education; Hospital and Medical Staff Organization; Financial Support; Nursing Education and Service; Structural Re-habilitation, Maintenance, and Operation; Medical Social Service; Food Service; Special Therapy; Medico-Legal Problems; and Medical Records. The Institute will be directed by Benjamin W. Black, M.D., Oakland, Cal., with the co-operation and participation of such well-known leaders as Ray Lyman Wilbur, M.D., President Stanford University; James A. Hamilton, First Vice-President A.C.H.A., Cleveland, Ohio; C. Rufus Rorem, Ph.D., C.P.A.; Sister John Gabriel, Seattle, Washington; A. K. Haywood, M.D., Vancouver General Hospital, B.C.; Robin C. Buerki, M.D., President-Elect A.C.H.A.; Malcolm T. MacEachern, M.D.

At Lagunita Court, one of the University dormitories, housing facilities may be obtained at the rate of $1.50 a day for single rooms. Meals may be had a la carte or table d'hote at the Stanford Union at the nominal charge prevailing for faculty and students of the university.

The Institute will be open to the following types of hospital personnel actively engaged in administrative work: Hospital Administrators, Administrative Assistants, Executive Department Heads. Further information may be obtained from the office of the Executive Secretary, Association of Western Hospitals, 1182 Market Street, San Francisco, California.

Three Wishes of a Record Librarian

By LILLIAN JOHNSTONE, R.R.L.,
General Hospital, Hamilton, Ont.

TO choose three from among the many wishes of a record librarian imposes some strain upon one's judgment, because, I am sure that there will be general agreement with the statement that most record librarians could not adequately cover their urgent requirements in three wishes only.

A friend of mine, with whom I discussed the matter recently, suggested to me that the wishes of "Faith, Hope and Charity", might cover the field, and indeed these three Christian graces, if possessed, and practised, not only by the record librarian herself, but also by those for and with whom she works, would go far to make her work more pleasant and efficient.

Faith is defined as "the substance of things hoped for, the evidence of things not seen". Hope, according to the dictionary, is the "desire for something good with at least a slight expectation of obtaining it". Charity according to the Bible, "suffereth long and is kind, envieth not, is not easily provoked, thinketh no evil, beareth all things, believeth all things, hopeth all things, endureth all things". Truly the greatest of these is charity.

But to get down to the more practical field of mundane things, there are, to my mind, three things for which the record librarian might wish, which, in importance to her and to her work, outweigh the others. These wishes might vary, of course, because all hospitals do not lack the same things. In so brief a presentation, details must necessarily be lacking but, if the general principles are given, details will take care of themselves. All librarians are constantly looking for improvement and I am sure, if they had an Aladdin's lamp, would wish for certain things, three of which might be:

1. Sufficient personnel and equipment.
2. Adequate histories for filing.
3. Uniform adoption of a standard nomenclature of disease.

Sufficient Personnel and Equipment

Now we rub the Aladdin's lamp and wish for sufficient personnel and equipment. The record librarian needs more help, perhaps, than any other worker in the hospital. She wishes to give every possible type of service to the physicians, interns and nurses who frequent her department. The institution might provide sufficient personnel, both in numbers and quality to carry out the duties of the office, adequate physical equipment, storage space, office furniture, etc., all arranged in such a manner as to facilitate the use of the record room, to the highest degree, by those who frequent it, with the minimum interference with the routine work of the department. It is a distressing situation if the workers are forced to work at high pressure every moment of the day. Efficiency is not to be obtained under such conditions. At first the record librarian, as we knew her, was a clerk who filed the histories of the patients discharged from hospital and obtained those records from the files whenever they were required. The next step was the compiling of reports, the next was the cataloguing of diseases. These developments have elevated the position from that of a filing clerk, so that the record librarian of to-day must be a person of varied accomplishments.

Now for the problem of a sufficient staff in this department. We should have workers, all of whom are honest, efficient and reasonable. In 1929, Dr. Parnall, then President-elect of the American Hospital Association stated, "that to be successful, workers in the record department should possess an unlimited amount of common sense, a neat appearance, a certain devotion to duty, a sense of adaptability and, at all times observe a highly ethical attitude". The perfect set up, to my mind, outside the room itself would be to have a stenographer in the operating room, one for each service of the hospital and one in the admitting room.

The record room should be conveniently located so as to save time for the visiting men and to save confusion in the department itself, in its relations and connections with other departments of the hospital. There should be sufficient room for filing of charts and proper accommodation for doctors who desire to make studies of certain charts.

Adequate Histories for Filing

This second wish, perhaps, outweighs the others. The librarian can work only with the material that comes to her department, hence the success of this department depends upon co-operation. Not only the co-operation of the record department with the nursing and medical services of the hospital but co-operation between the heads of the different services and between these heads and the interns. The chief aim, of course, is the securing of good histories. Time and time again interns have been known to write good histories only to have them passed up entirely by the visiting staff doctors. The present illness of the patient is of primary importance to the intern and, if the visiting doctor does not read the history, the intern will tend to become discouraged and as the year goes on histories become less adequate. One instance is brought to mind where, on an operating sheet, when it reached the record room, was written the word "Hysterectomy". When asked for notes on the operation, the reason for the operation, and the type of hysterectomy performed, the surgeon replied, "that as far as he could see, all the use of the record department was to irritate doctors". Not six months later this same doctor complained when making a study of certain charts, that the notes on the records were inadequate. This might be eliminated by a stenographer in the operating room or perhaps by a record committee. The committee might serve as the authority behind the record librarian and serve as a connecting link between the worker and the general staff in maintaining certain standards. Everywhere will be found the problem

Presented at the O.H.A. Meeting, Oct. 20, 1937.

of getting doctors to complete charts promptly. Very seldom does the chart come to the record room complete in every detail. I have always wished that the doctor who wrote the diagnosis on the sheet might be a man familiar with the actual case.

In the record room is established the life history of the hospital, its reputation for accurate diagnosis and successful treatment. The structure can be no better than the individual elements entering into its construction, and the quality of these elements is almost entirely the result of the concerted and intelligently directed efforts of the co-workers.

Now we come to the nurses' notes. If possible each student nurse or perhaps each charge nurse might spend some time in the record room. They would then see the endless repetition of certain phrases in the notes, the inconsequential remarks and the inadequate recording of important events in the history of the case. Nurses' notes are useless unless accurate. The chief complaint I have is that the time is sometimes not recorded. We find this often in court cases.

A Standard Nomenclature

We come to the last wish and rub the lamp, "Uniform adoption of a standard nomenclature of disease". Without this any statistical survey is extremely difficult and unsatisfactory. Here is where the competent record committee might function. Many diagnoses appear upon our charts which are not recognized by standard nomenclatures. In our hospital we adopted in the year 1933, the "Standard Nomenclature of Disease", edited by a Joint Committee of which Dr. H. B. Logie of New York City was chairman. We can most heartily recommend this nomenclature to any hospital. We find it makes for accurate detailed diagnoses. For example under most systems a disease is classified under "Diabetes Mellitus". Under this system Diabetes is classified first roughly as a metabolic disease, secondly the book attempts to tell the origin of the Diabetes, thirdly it classifies Diabetes with Acidosis or without Acidosis. If gangrene is present and the kind, wet or dry, it will be stated. We find this Nomenclature is offering greater facilities to the doctors who are searching the records for particular points. If he be a surgeon looking for amputations in patients suffering from Diabetes or if he be a medical man looking for some particular complication the information is there. As far as I know there is no other system which will offer that.

The forwarding of the diagnosis of discharged patients to the Provincial Department of Public Health at Toronto, has made for decided improvement in diagnosis.

Granted the fulfilment of these three wishes, the record librarian should have no difficulty in having the most exacting hospital administrator view with pride the records of his hospital.

Presbyterian Hospital, Chicago, Publishes Intern Bulletin

The regular monthly bulletin of the Presbyterian Hospital of Chicago, of which Mr. Asa S. Bacon is the well-known superintendent, has recently devoted one of the regular numbers to a review of its intern staffs. A feature of the issue is a list of all of the interns in previous years, dating back to the first intern in 1884. An interesting article is contributed by this first intern, Doctor Lawrence H. Prince, who, some years later, originated the widely used open drop method of etherization. Doctor Prince writes in part:

"We had but few medical cases and no obstetrical work at all during my stay. As I recall there was a staff of eight nurses but I cannot remember the number of patients. I know, however, that there was no time when there were not several cases requiring many dressings. The dressings of those days were of the voluminous kind. Abdominal operations were just being made and asepsis was being introduced.

"Medical students of that time were particularly fortunate because of the opportunity offered to study the revolutionary steps from the pre-antiseptic days to the anti-septic methods which were the beginning of modern aseptic surgery. At college I heard both sides discussed with enthusiasm. There were those who urged 'no healing without suppuration' and talked of 'laudable pus', terming the germ theory a 'myth'. On the other side, we heard about 'air borne germ infection' and other theories which have revolutionized surgical technique. At that time the carbolic acid spray was largely depended upon."

Sweepstakes for Hospitals

(Continued from page 14)

a. Sweepstakes should be directly under the Federal Government and not under any private management;

b. Sweepstakes should be nationwide or not at all;

c. Receipts to hospitals from sweepstakes *should not replace, but be supplemental to,* present provincial, municipal and other sources of income. Receipts should be used to finance hospital service not generally possible at the present time. A movement to reduce grants to hospitals could be anticipated, but this should be considered only after adequate assurance be given that the future maintenance of the hospitals would not be jeopardized.

d. Expenses, salaries and other overhead should be reduced to the minimum, as in the case of government annuities or soldiers' insurance;

e. A much larger proportion of the money received should go to hospitals;

f. The percentage for prizes should be kept well below fifty per cent, preferably not over forty per cent, and individual prizes should be smaller, thus making more awards and reducing the chance of personal demoralization;

g. The permanent allocation of all benefits to hospitals should be carefully provided for. Distribution to the various hospitals should be in accordance with a clearly defined and equitable policy and should be controlled by a non-political commission.

The
PRIME MINISTER OF CANADA
Sends Greetings for
NATIONAL HOSPITAL DAY

OFFICE OF THE PRIME MINISTER
CANADA

Ottawa, April 20, 1938.

G. Harvey Agnew, Esq., M.D.,
Secretary, Canadian Hospital Council,
184 College Street,
Toronto 2, Ontario.

Dear Dr. Agnew:

I wish to avail myself of your letter of April the twelfth, to extend a word of cordial greeting to the Canadian Hospital Council, on the occasion of National Hospital Day.

It is indeed fitting that the observance of National Hospital Day should coincide with the commemoration of the birthday of Florence Nightingale, the founder of the modern system of nursing. An energetic and courageous administrator, gentle and loving to the wounded, Florence Nightingale raised the art of nursing to an honoured vocation. She not only effected far-reaching reforms in the medical work of the army, but brought her knowledge and skill to the service of the community as a whole. To her, in no small measure, are due the revolutionary changes which, in the past century, have occurred in the attitude towards the treatment of illness, domestic hygiene and public health.

Humanity, and not the State, should be the supreme concern of society. The wealth of a nation lies, not alone in abundance of material resources, but in the health and welfare of the people. Physical well-being is essential to sustained national progress. Health is, thus, a public asset, which must be safeguarded, and its protection has become a fundamental responsibility of society.

In this, as in other fields of activity, mutual aid and voluntary effort play a large and important part. With present day modes of life involving, as they do, an increasing measure of strain, there is, today, perhaps as never before, necessity for loyal and constructive support, on the part of an understanding and sympathetic public, of institutions for the care of the sick and disabled. There is no cause more worthy of whole-hearted assistance than that which seeks, in this immediate and practicable way, to assure the happiness and well-being of the Canadian people.

I send my best of wishes for the observance of National Hospital Day, and for the work of the Canadian Hospital Council in promoting the welfare of community and national life.

Yours sincerely,

W. L. Mackenzie King.

This wholehearted support of the work of our Hospitals is deeply appreciated throughout the Dominion.

Obiter Dicta

Creating Interest in Your Convention

THE time for the annual provincial or Sisters' hospital conventions will soon be upon us and it is well that association executives and convention committees give early thought to the desirability of creating early and widespread interest in these meetings. Right across the country, we have annually a wonderful series of meetings, conventions where those in attendance are rewarded tenfold for their effort to attend, not only in actual knowledge gained but in added inspiration and enthusiasm with which to tackle the everyday problems of hospital life. The sad aspect of these meetings is that so many other administrators, trustees, physicians, nurses and others are not there to benefit by the discussions.

The time to start your advance publicity is NOW. The mailing of the program a couple of weeks before the meeting is not good enough. Administrators, trustee boards and the staffs should be subjected to such a barrage of publicity that the individual will come to the conclusion that, come what may, he simply cannot afford to miss that meeting. By mimeographing letters there can be a wide coverage with a minimum of secretarial effort and of expense.

The following suggestions have amply proven their merit:

i. *Complete your program early.*
   (a) Diversify the subjects to create general interest. Many programs are too brief to have general appeal.
   (b) If speakers not finally selected, list subjects anyway; it is usually the subject that primarily brings out the attendance.
   (c) List discussants, thus creating broader interest and participation.
   (d) Use intriguing titles for subjects. Get away from hackneyed titles that breathe boredom.

ii. Send out preliminary letters weeks in advance. Make them racy in style and bursting with enthusiasm.

iii. Feature selected portions of the program in the various letters. At the propitious time send out the advance draft of the whole program.

iv. A letter to the administrator is not enough. The chairman and secretary of the trustee board, or better, the whole board, should also be circularized. The secretary of the medical staff should receive copies, the head of the school for nurses, and others.

v. Suggest that those with cars bring three or four others. Feature the social items to interest others in the hospital family.

vi. Urge them to bring *their* special problems. The other fellow may have the solution.

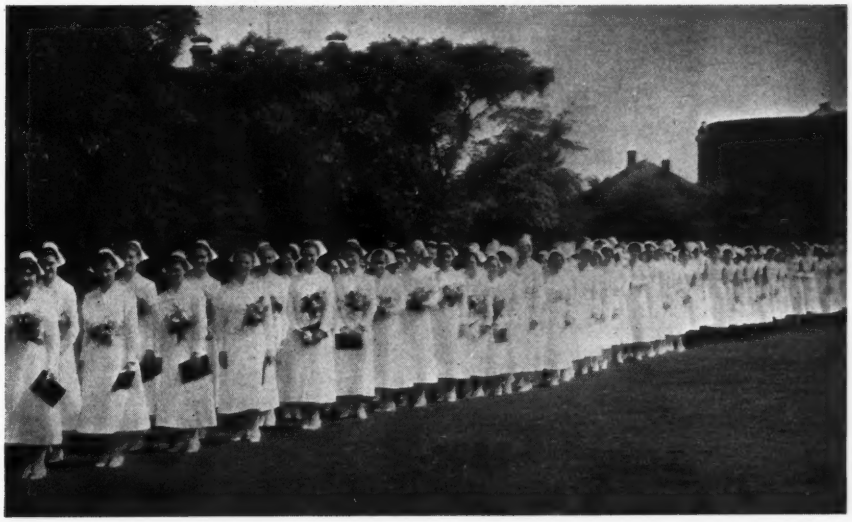
Try these tactics and watch your convention grow!

Have You Analyzed Your Own Statistics?

IT has been revealed, many times, both by questionnaire and at convention round tables, that the majority of hospital administrators have difficulty in giving any more than a very limited statistical analysis of the work of their hospitals. Most hospitals, of course, have readily available their patient-day cost, their annual admissions or perhaps their raw food per meal costs, but it would be not only of interest but of distinct value to have available such further analysis as the comparative cost of caring for private and public ward patients, the all-inclusive cost of a meal, the cost of a confinement, of caring for a newborn infant, of laundry steam, of a major operation or of caring for a diabetic. One of the difficulties encountered in settling the old controversy of the relative cost of graduate vs. undergraduate nursing is the lack of comparative statistics and the fact that all too many of the figures now available omit certain essential considerations.

It would be revealing to ascertain how many pieces of laundry are used per patient per diem. The cost per piece or per pound, when done in the hospital, is essential for any comparison with an outside laundry service. What is the average length of stay for ward patients or for private patients? It is a fact that, in many small group hospitalization plans in Canada, statistics are not available as to percentage incidence of hospitalization, length of stay as compared to other patients or relative morbidity of wage-earners and dependants.

Without doubt the lack of clerical assistance has been one reason for this dearth of available information. Most hospitals, particularly the smaller ones, are distinctly short of office assistance, and the administrators rightly focus their limited resources upon those activities most essential to the welfare of the patient. Despite these reservations, however, it is most desirable for each hospital to have such data readily available for its own information and use. Properly organized businesses know their unit costs and coverages to the decimal point; if our hospitals are to retain public confidence, they would be well advised to more fully develop those business-like procedures which reveal a thorough study and analysis of their operation costs and procedures.



Congratulations to all Graduating Nurses!

THIS month and next will see some two hundred processions and more of attractive immaculately-garbed young ladies filing across the flower-bedecked platform in as many hospitals or halls to receive their graduation pin and parchment. Back of the gaiety of the occasion, the applause, the music and the laudatory addresses lies much that cannot be part of the program. The final culmination of that dream long cherished from childhood, the passage through that magic portal after years of study and struggle, the heartache soon to come when bosom friends and classmates must scatter to their lifework, the sacrifice and loneliness of the distant family, all forgotten now as they proudly watch award, and perhaps special honour, come to their daughter—untold and unspoken emotions surcharge the atmosphere like unseen radio waves and give to the nurses' graduation an appeal shared by few other occasions.

To these new-fledged nurses, the whole hospital world extends its heartiest congratulations and welcome.

The New Cover

IN keeping with the springtime spirit, it has seemed appropriate to select this issue for a change of cover. The Editorial Board hopes that you will be pleased with this choice. It has appealed to the Board as being most suitable for this type of magazine. The design is essentially a dignified one, it is well balanced and the lettering portrays strength and character. Simplicity has been preserved. The use of a large unbroken expanse of colour balanced with a severe and carefully placed linear relief is in full accordance with the modern conception of design.

Montreal Hospital Council Appoints New Officers

The following officers were appointed at the Annual Meeting of the Montreal Hospital Council: President, Mr. J. H. Roy; 1st Vice-President, Dr. J. C. Mackenzie; 2nd Vice-President, Mr. R. L. Laporte; Treasurer, Dr. Edmond Duke; Secretary, Dr. A. Lorne C. Gilday.

The following delegates and alternates were appointed to the 1939 Canadian Hospital Council meeting: Mr. J. H. Roy, Mr. W. R. Chenoweth, Mr. J. H. Panneton (alt.), and Dr. J. C. Mackenzie (alt.).

Insulin in Treatment and Nutrition With Regard to Certain Mental Disorders*

By T. E. DANCEY, M.D.,
Resident Physician, Verdun Protestant Hospital

SHORTLY after the discovery of insulin, a German physician began using it to treat mental patients. However, the procedure was apparently not successful and was abandoned for a time. In 1929 Sakel, a young Viennese psychiatrist, interested in the treatment of drug addiction, gave his patients injections of insulin with favourable results. The sedative effect and sense of well-being which were produced did much to relieve the awful suffering consequent to withdrawal of morphine or heroine.

About 1931, Dr. Reed of this hospital, having never heard of Sakel or his work, began using insulin to ameliorate the withdrawal symptoms in drug addicits and also in alcoholics. One of the most striking observations was the stimulation of an appetite for food. These individuals usually come for treatment as a last resort. They are in an irritable, unstable mental state. Frequently they have taken very little food for many days; they say they cannot eat as they are not hungry; the very sight of food nauseates them and may produce actual vomiting. Small doses of insulin half an hour before meals disperses this nausea and stimulates an appetite. The patients rapidly become less irritable and more co-operative. A gain in weight is soon recorded and after a short time the subjects no longer even suggest that alcohol or morphine might help them. Addiction to alcohol or drugs is usually found in unstable, inadequate persons, who, if not actually mentally ill, are on the border line. By treating them with insulin we do not presume to offer a cure for their mental condition; we merely shorten the withdrawal stage and ameliorate the suffering during that stage.

We occasionally give small doses of insulin (10 units) one-half hour before meals to underweight patients with a poor appetite, hunger usually becomes manifest and the patients soon gain weight.

Sakel was so struck by the sedative effect of insulin that he began using it in relatively large doses on other types of cases. Some schizophrenics accidentally lapsed into coma and when they were awakened by the administration of sugar the mental improvement was spectacular. In 1933 Sakel published his new procedure for the treatment of schizophrenia—"Insulin Hypoglycaemic Shock Therapy". Since that time this method has been employed in practically every country in the world.

Let us pause for a moment and seek to answer a question which no doubt has arisen in your minds. What is meant when we speak of Schizophrenia or dementia praecox? If you were asked individually to name the most terrible disease to which human flesh is heir and with which medical science has been unable to cope, many of you would say cancer. But cancer usually gives its victims many years of useful life and when it strikes it produces death with relative rapidity. Tuberculosis causes much suffering and is very incapacitating. In certain areas of the world leprosy is looked upon with horror, as it necessitates the segregation of its victims, and disfigures them beyond recognition. Cholera and severe influenza have taken a great toll of human life in the past, but death with these diseases is rapid and free from long extended suffering.

Schizophrenia usually begins in the teens or early 20's. It is, as a rule, characterized by a gradual shutting out of normal interests, the regard for healthy amusement, the natural ambition of youth, the love for parents, husband, wife or children—all these things are lost, and the victim, in the very morning of life is left marooned on the barren rock of insanity. Some of these unfortunates are subject to horrible visions and hideous imaginary voices which produce a marked degree of agitation and confusion. Some escape by suicide; many succumb to tuberculosis. The others for centuries have been encarcerated in mental hospitals when their conduct has become sufficiently asocial, and there they spend their lives. They are incapable of useful work and gradually deteriorate to a state of living death where they may recognize no one and cannot themselves be recognized by those who once called them friends. Often the victims of this disease are those who gave early promise of becoming brilliant members of society. In our insulin clinic we have treated two lawyers, one Rhodes scholar, one young man, who had been studying for the priesthood, two bachelors of arts, two private secretaries, and two graduate nurses. Do these people ever recover! Occasionally they appear to do so, but too often, after a few months another attack occurs. Even those who are allowed to leave the hospital usually show mental scarring manifested by eccentric behaviour, poor judgment and a general apathy. One man, who has given the subject careful study, estimates that only 6% fully recover. Schizophrenia is a costly disease, not only because of the human suffering and incapacity which it produces but also because of the economic factors involved. During 1933 $4,500,000 was expended in the care of victims of this disease in Canada.

Contributed by

The Canadian Dietetic Association

Ruth Davidson Reid, B.A.
Montreal
Chairman
Publication Committee

*Read before the Montreal Dietetic Association at the Verdun Protestant Hospital, April 25, 1938.

Although the effects of this disease on the human subject are so well known, our knowledge as regards the cause or origin of the malady is practically nil. Therefore, as might be expected, there is no rational treatment. Our ancestors, believing possession by the devil to be the cause, attacked the disease by incantations and floggings to drive out the evil spirits. Purging and bleeding were used even toward the latter part of the last century. During the past 25 years numerous methods have been tried; the production of high temperature, prolonged unconscious states by means of drugs, modification of psychoanalysis, artificial meningitis, are a few of these procedures. Meduna of Budapest recommends a drug called metrazol which produces convulsions. A Portugese psychiatrist subjects his patients to a brain operation during which certain parts of the brain are cut with a knife.

For nearly one year we have been treating schizophrenics with large doses of insulin and our results have led us to believe that this is the method of choice. The technique consists of giving the patient gradually increasing doses of insulin (old type) until a state of coma is produced. This coma dose is then repeated daily until all evidence of the mental illness has disappeared.

Typical Case Treated

For purposes of clarity let us examine the case of M. N., a female, aged 28, whose illness began in February, 1937, after the birth of her first child. She constantly heard imaginary voices talking to her. She was continually grimacing; she paid very little attention to anything that was said to her; her language was abusive and vile; she was destructive to her clothing; she hated her husband's very name. On May 25, 1937, she received 20 units of insulin intramuscularly at 8 a.m., having had nothing by mouth since 9 o'clock the previous night. At 11 a.m. she was given 5 oz. 50% sucrose solution flavoured with orange juice. Each following day at the same time she received an additional 10 units until on the fifth day, with a dose of 60 units, she began to perspire freely at 10 a.m. She was very excited at 11 o'clock and was demanding food. She continued in this state until 12.30, when she was given her sugared drink (grams 1-2 sugar for each unit of insulin). On the 11th day of treatment with a dose of 120 units the patient became comatose just before 12 o'clock. At one o'clock a nasal tube was inserted and 10 oz. of 50% sucrose solution placed in the stomach. In 20 minutes the patient began to awake and in 25 minutes was sitting up asking for food. After her lunch and a bath she was taken for a walk and it was sought to interest her in knitting and magazines. After a week or so of daily treatment, except for Sunday, it was discovered that the patient required a smaller dose of insulin and would actually go into coma with 80 units. After about 50 days of treatment she began to talk about her child, to show some interest in her husband, her personal appearance and her surroundings. She was allowed to go for drives and on one occasion tried to play tennis. She had gained 8 pounds. She then suddenly relapsed to her former mental state when she was uncooperative, destructive and extremely silly in her behaviour. At the same time she developed a tolerance for insulin and her dose had to be increased to 170 units before coma again developed. After one week of treatment with this dosage, all her mental symptoms disappeared, and after a few days she was allowed to go home. She has remained well for eight months.

Although the above is a fairly typical example of the course of insulin shock treatment when applied to a case of schizophrenia, we find that each patient must be judged individually as regards the dosage of insulin, the duration of treatment, the depth of shock, as well as the hour to hour reaction during any one period of hypoglycaemia. Some patients recovered rapidly when awakened each day during the most excited period. These individuals do not require actual coma. About 1/3 of the cases treated develop convulsions from two to four hours after the administration of insulin. They are always given sugar intravenously or by nasal tube as soon as possible after such a phenomenon. These seizures are at times productive of good results and if this appears to be true it is possible to stimulate a convulsion every second day by injecting a drug called metrazol.

Most patients awake within half an hour from the time the sugar solution is given by nasal tube. If they have not awakened in this time they are given from 80-200 ccs 33 1/3% glucose in normal saline intravenously. This acts rapidly, requiring 2-8 minutes to produce the desired effect. Very occasionally there develops a more or less irreversible state of coma during which the patient fails to awaken despite any measures which may be instituted.

There are wide individual variations in the coma dose of insulin. One of our patients required 365 units; another developed coma with only 21 units.

There is one constant factor which must always be borne in mind. I am referring to the duration of illness. About 80% of patients recover who have been ill for six months or less. After 18 months of illness, although recovery is occasionally seen, improvement only can be expected.

What effects are produced when a large dose of insulin is injected? The blood sugar is rapidly lowered to 20-30 mgs. percent during the first 2-3 hours. Such symptoms as perspiration, excitement and sleep develop at a level of around 50 mgs. percent. Strange to say the blood sugar level begins to rise very slightly after the first marked fall so that when the patient is in the deepest coma the sugar level is not necessarily at the lowest point. Available stores of glycogen such as that in the liver have been used; adrenalin is poured out from the adrenal glands to counteract the insulin effect. As this is of little avail it seems likely that the fat in the muscles is then converted to glucose. The brain has not the power to use fat and so must exist on the extremely small stores of sugar which it possesses. When sugar is not available for oxidation then the oxygen consumption of the brain is practically abolished or at least cut down to the degree necessary for the continuance of life. The fact that the brain is kept in such a state for a few hours each day may possibly kill off certain diseased cells.

Why do patients receiving insulin treatment gain weight? The lowering of the blood sugar appears to stimulate an enormous appetite. However these patients miss one meal each day and often do not receive their lunch until 2 o'clock in the afternoon. Some individuals are even nauseated and take very little food until evening. One of the affects of insulin is to store sugar in the muscle and liver. Probably

a good part of this sugar is converted into fat and this may explain the gain in weight.

A few patients continue to gain weight even when the course of treatment is completed. A physiologist states that this may be due to the fact that the stomach was actually stretched during treatment because of the large meals eaten, They continue to take more food than they realize in order to obtain that satisfied feeling which a good meal produces by filling the stomach.

This treatment is drastic and by no means devoid of danger. Prolonged periods of irriversible coma may terminate in death, as was the case with one of our patients. Sudden death has been known to occur because of unrecognized heart disease. However, a mortality rate of 1 to 2%, which appears to be true, is not unduly high when one considers the severity of the disease involved.

Well trained and efficient nurses are essential both during the period of hypoglycaemia and following this state, as a secondary reaction may occur as late as the early morning of the following day, and to the uninitiated may be mistaken for natural sleep.

The following table is included to demonstrate the number of cases treated, their age and sex, the duration of illness, the number of treatment days, the amount of insulin given, the change in weight and the result of treatment.

The average gain in weight for the twenty-seven cases treated is 11.88 lbs. The two patients who lost weight developed status epilepticus and each required an anaesthetic so that for many hours they could take no food by mouth. They both recovered immediately following this phenomenon.

Patient	Age & Sex	Duration Illness	No. Days Treated	Amount Insulin (units)	Change in Weight	Result of Treatment
1	F. 28	4 mos.	27	3205	+27	Full Recovery
2	F. 28	3 "	75	7022	+11	" "
3	F. 33	6 "	37	2701	—1	" "
4	F. 27	1 mo.	42	5981	+6	" "
5	F. 31	4 mos.	32	2104	+6	" "
6	F. 34	5 "	16	1392	+6	" "
7	F. 18	3 "	31	4426	+19	" "
8	F. 24	3 "	22	2090	+12	" "
9	F. 32	3 "	17	1952	—3	" "
10	M. 18	18 "	47	4598	+11	" "
11	M. 26	2 yrs.	37	3884	+20	" "
12	F. 31	2 "	74	8695	+18	Much Improved
13	F. 37	2 "	83	10763	+10	" "
14	F. 25	5 "	82	16011	+6	" "
15	F. 38	7 "	71	2095	+25	" "
16	M. 16	2 "	69	11588	+10	Improved
17	F. 28	5 "	45	2384	+16	"
18	F. 27	8 "	69	8958	+16	"
19	M. 30	12 "	84	16484	+25	"
20	F. 22	1 yr.	88	12916	+12	Negative
21	F. 26	3 yrs.	52	3532	+14	"
22	F. 25	4 "	80	12973	+8	"
23	M. 27	5 "	73	10057	+22	"
24	M. 23	2 mos.	30	3983	+14	Discontinued
25	F. 32	2 yrs.	42	6835	+3	"
26	F. 22	5 "	16	1792	+6	"
27	F. 42	6 mos.	54	4340	+4	Died

Voluntary Blood Transfusion Service Formed in Victoria, B.C.

A Voluntary Blood Transfusion Service has been organized in Victoria, B.C., the object being to acquire 100 free blood donors and so be prepared for any emergency. Fifty are already registered, 25 men and officers of the Princess Patricia's Canadian Light Infantry and the Royal Canadian Army Medical Corps being on the list. Dr. G. A. McCurdy, who is in charge of the laboratory at the Royal Jubilee Hospital, is one of the committee organizing the service.

Dental Clinic for School Children Installed at the Niagara Falls General Hospital

The Lions Club has opened up a dental clinic at the Niagara Falls General Hospital, after an intensive study of the needs of such a service in the community by the school nurses. This service is extended to students of the city of Niagara Falls and Township of Stamford, attending public and separate schools, whose parents or guardians are financially unable to secure this attention for their children, through the regular channels.

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Plans for Canadian Dietetic Association Convention in Ottawa in June

The plans for the convention of the Canadian Dietetic Association which is to be held at the Chateau Laurier, Ottawa, on June 13th, 14th and 15th, are proceeding rapidly. The Ottawa hostesses are arranging various entertainments and the programme committee has completed the following arrangements:

MONDAY, JUNE 13TH, Exhibitor's Luncheon—Speaker, Mrs. Geo. Black, M.P. for Yukon.

Afternoon Session—Annual meeting and election of officers.

Evening Session—Group Dinners:

(1) Hospital and University Section, Dr. Geo. F. Williamson, Ottawa.
"The Role of Dietetics in Dermatology with Discussion of Cutaneous Manifestation of Food Allergies", Dr. Douglas Taylor, Royal Victoria Hospital, Montreal.
"Diet and Arthritis".

(2) Commercial Section, Mr. Arengo Jones, Ottawa.
"Frozen Fruits and Vegetables". A dietitian from The Robert Simpson Co. will speak on "Food Costs".

(3) Social Welfare Section. Speaker, Miss Frances McNally, Acadia University.

TUESDAY, JUNE 14TH:
Dr. E. R. Thompson, McGill University, "Recent Progress in the Study of Vitamins".
The afternoon session will be devoted to Diet Therapy.

WEDNESDAY, JUNE 15TH:
Morning Session—Round Table Discussion.

Afternoon Session—Commercial Open Forum, presided over by Miss Lorena Richardson, The Robert Simpson Co., Toronto.
Speakers—Mr. Charles Fuller-Stoddard, Butler Hall, N.Y.
"Operating a Restaurant along Scientific Lines", Miss Marie Casteen, Statler Hotels, N.Y.

It is hoped that Miss Lenna F. Cooper, President of the American Dietetic Association will bring greetings to our convention.

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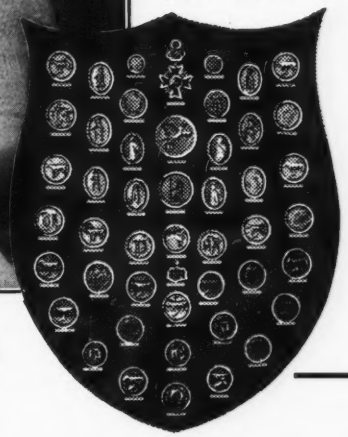

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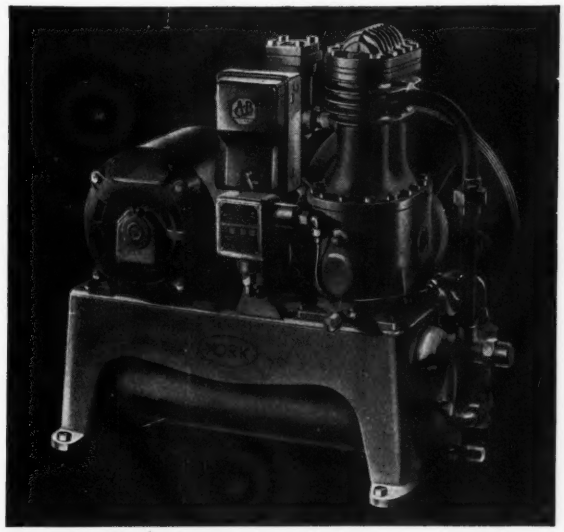

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Hospital Care Revolutionized in the Carolinas

Small Hospital Work of the Duke Endowment of Particular Interest in Canada

By HARVEY AGNEW, M.D.

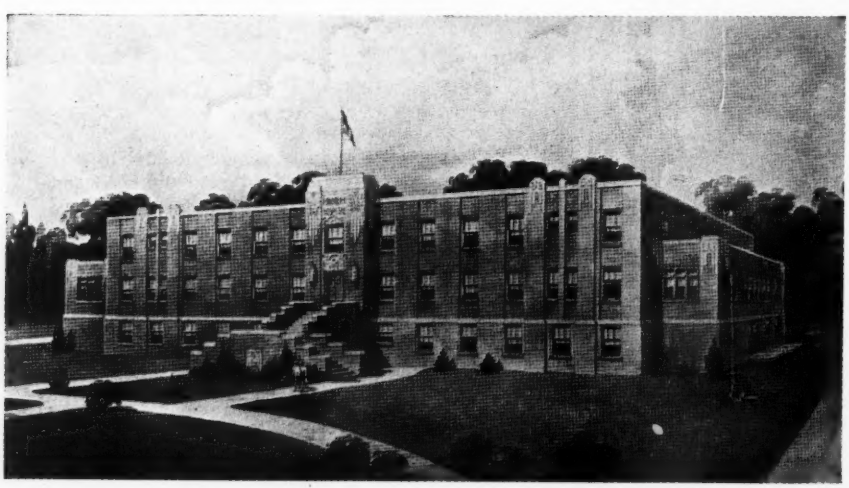
ONE of the finest of object lessons in the development of adequate hospital facilities is now being enacted in the Carolinas. Thanks to The Duke Endowment, these two states are now blessed with one of the most noteworthy chains of smaller hospitals on the continent.

Recently the writer had the privilege of visiting a number of these hospitals under the guidance of Dr. W. S. Rankin, Director of the Hospital and Orphans Section of The Duke Endowment, and his invaluable assistant, Mr. Graham Davis. On this delightful tour, which extended for 700 miles through North Carolina, up over the blossom-clothed Great Smokies, down into Tennessee and finally into Alabama, we were accompanied by Mr. Oliver Pratt of Salem, Mass., Chairman of the Small Hospitals Section of the American Hospital Association.

Rural and smaller town hospitalization in most of the southeastern states has been comparatively backward. Many large areas have no adequate hospitalization at all. In all probability one major factor has been the lack of local or state grants, thus discouraging the establishment of voluntary local hospitals by altruistic citizens. The result has been that, in scores of instances, doctors have been forced to build their own hospitals in order to do proper work. While in some instances these have paid, in all too many instances they have proven to be an asset of a distinctly glacial variety. Control of the work done has been very uncertain. Since 1926, in the Carolinas all this has been changed.

The Duke Endowment, amassed through tobacco and, later, power interests and amounting to over 100 millions, is devoted to furthering the work of Duke University and other educational institutions, to hospitalization, to rural churches and preachers and to the care of orphans. Approximately $1,200,000 is devoted annually to furthering the work of about 125 hospitals; of this some $900,000 is distributed on the basis of $1.00 per patient-day for the care of charity and part charity patients, the balance being for capital expenditure. When a new hospital or addition is required, an approximate third of the cost may be contributed by The Duke Endowment. Formerly a higher proportion was given, as at Sanford, where half of the cost of $130,000 was contributed. At Salisbury $70,000 was donated. Altogether 68 building projects have been assisted; of these 24 were new plants. All proposed sites and plans must be reviewed, and endorsed by Dr. Rankin and his associates.

The result has been the building up of a wonderful network of hospitals throughout these two fortunate states. A number of typical institutions were visited. Most of these were of about 50 or 60 beds capacity. All constructed with the aid of The Duke Endowment showed the same basic type of layout, although no two were exactly alike. A number of these are reproduced in the well known Bulletin No. 3 of The Duke Endowment. There are separate entrances for service, for emergencies and for the colored patients, the latter being housed in good quarters at one end of the basement floor. All will permit extension backward in T-fashion. Diagnostic and therapeutic facilities are above the average for this size of hospital.



Randolph Hospital, Inc., Asheboro, North Carolina.

Work Carefully Checked

This subsidy for ward patients is quite suggestive of our Canadian system; in fact, Dr. Rankin is very generous in stating that the inspiration for this basis of assistance came from Canada and he speaks most appreciatively of the assistance given to him back in 1925 by the late Dr. Seymour of Saskatchewan. Moreover, as in Canada, the work of these hospitals is carefully checked; actually the returns to The Duke Endowment are much more detailed than anything required here. The form upon which re-

turns are made covers 18 pages and requires sworn answers to some 214 questions, a number of which occupy several pages. Both administrative and clinical details are analyzed to an unusual degree.

As a result The Duke Endowment acts *in loco parentis* to these hospitals. Costs are analyzed and compared, weaknesses are noted and suggestions offered. Results are studied and the development of scientific work encouraged. If the average stay is too high, the hospital is notified. Each hospital is autonomous, as in our own system, but The Duke Endowment does not hesitate to advise and warn the hospital should occasion warrant. Rather than resent this supervision, the hospitals and their staffs obviously appreciate this assistance. Moreover, unlike the most of our municipalities and governments, The Duke Endowment likes to see a healthy operating surplus. The viewpoint taken is that the hospital should be encouraged to increase collections and to effect economies; any temporary surplus would soon be utilized in providing additional services to the public.

Professional Work Controlled

The medical arrangements in many of these small hospitals is dissimilar in some respects to the "open staff" arrangement usually prevailing in our smaller hospitals. In many communities only a limited number of the local doctors have ward privileges. In some the surgical work is limited to but a few doctors, whereas in nearly all of the smaller hospitals in this country any local doctor may attempt his own surgery. In these rural areas the line between the surgeon and the general practitioner seems to be much more clearly defined than in similar rural areas of Canada. At Shelby, for instance, in the 75-bed hospital, the surgery is limited to two doctors only; at Asheboro, the surgeon to the 37-bed $131,000 hospital lives in another town some 15 miles away.

Apparently there has been a lack of men in these rural areas qualified to do surgery. To encourage the right men to come into the areas and properly utilize these new hospital facilities, The Duke Endowment has co-operated with the local authorities in holding out special inducements to qualified surgeons. At Elkin, for instance, the surgeon was guaranteed so much per month or 80 per cent of earnings, the hospital making the collections and providing office space and maintenance. The arrangement is proving satisfactory to both parties. Pinehurst hospital brought in a surgeon on a somewhat similar basis and the arrangement has proven quite lucrative, particularly to the hospital

This arrangement has resulted in a high level of surgical competence in these rural hospitals. One doubts if it would prove acceptable here, however, because of the insistence of the practitioner in smaller centres to the right to do his own surgery, if he so choose. The present intention of The Duke Endowment, for instance, to bring a new surgeon into a certain community where the surgery at the present time is not good enough indicates a high degree of protection for the public, but is a procedure which so far has not been developed here. Perhaps the common practice of setting up hospitals owned by private doctors would explain also why the medical profession in these states is accustomed to leaving the surgery and certain staff privileges to a limited few.

The successful operation of this system of supervision and control bears high witness to the general respect felt by all for the integrity and sincerity of Dr. Rankin, Mr. Davis and their associates.

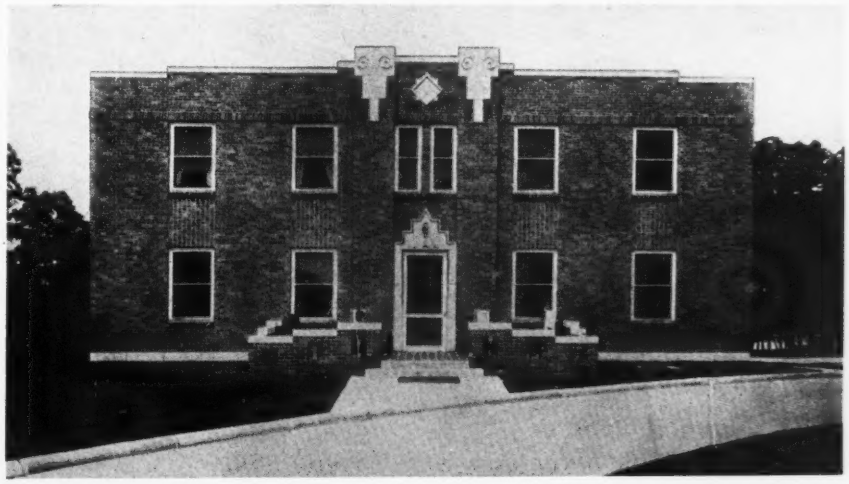
It was a delight to visit one little hospital, Rutherfordton, in the foothills of the Great Smokies. Here Dr. M. H. Biggs and his associates are operating a surprisingly fine cancer clinic. With a full gramme of radium in their possession and an up-to-date emanation plant, these men are setting a high scientific standard for that whole section of the state. We can learn much from our friends in the Carolinas.

Canadians Honoured

Sister Mary Mercedes, Assistant Superintendent of St. Joseph's Hospital, London, Ontario, and Clarence C. Gibson, Assistant Superintendent, Regina General Hospital, Regina, were among those elected to membership in the American College of Hospital Administrators at the spring meeting of its Credentials Committee. Forty-four administrators were accepted for membership or fellowship at that time. These members and fellows, with those accepted at the next meeting of the Credentials Committee in July, will be presented with their certificates at the formal exercises of the fifth annual convocation of the College at Dallas, Texas, on September the 25th, 1938. Congratulations!

Hospital Superintendent Appointed

Miss Ellida Walsh, for some time on the staff of Nicholls Hospital, Peterboro, has been engaged as superintendent of Renfrew Hospital. She has just concluded a post-graduate course in New York City.



Home for Nurses, Randolph Hospital, Asheboro, North Carolina.

Interesting New Statistics on Canadian Hospitals

THE Annual Report of Hospitals in Canada for the year 1936 has just been issued by the Institutional Statistics Branch of the Dominion Bureau of Statistics. There are 962 hospitals in Canada of which 544 are for the treatment of acute diseases and 58 for mental care. Public hospitals for acute diseases comprise 62.6% of all public and private hospitals, and contain 75.4% of their total bed capacity. There are 259 private hospitals. Total beds, cribs and bassinets, excluding mental and Federal hospitals, amount to 64,125, and the total number of patients under care in these hospitals was 861,427. There are 7,467 beds for tuberculous patients, and a total capacity of 2,582 for the care of incurables.

Use of Hospitals

The following table shows the patients under care per 10,000 of population:

Province	Per 10,000 population
Prince Edward Island	586
Nova Scotia	773
New Brunswick	585
Quebec	556
Ontario	767
Manitoba	1,000
Saskatchewan	903
Alberta	1,130
British Columbia, including Yukon and N. W. Territories	1,218
Canada	782

This would indicate an east to west trend in the utilization of hospitals. This is more obvious if the country be zoned.

Maritimes and Quebec	587
Ontario	767
Prairie Provinces	1,004
British Columbia	1,218

Births in Hospitals

It may be a surprise to many who realize that 35.9% of the living births in Canada in 1936 occurred in hospitals. This was an increase of exactly 6% from 1933. Of the still births recorded, 46.4% occurred in hospitals, an increase of 7.1% over 1933; this indicates not only an increasing use of hospitals for all obstetrical patients, but a realization that the hospital is the best place for the abnormal patient.

	Living Births	Still Births
Canada	35.9%	46.4%
Prince Edward Island	21.6%	30.0%
Nova Scotia	31.9%	62.6%
New Brunswick	18.6%	36.5%
Quebec	14.4%	20.4%
Ontario	47.3%	59.7%
Manitoba	50.3%	68.7%
Saskatchewan	42.3%	60.0%
Alberta	61.4%	76.5%
British Columbia	79.3%	90.0%

This analysis indicates that the lowest utilization of haspitals for obstetrics is in Quebec, and that the highest utilization is in the western provinces. There were 4,274 more infants born in hospital in 1936 than in 1935. The 2,949 still births formed 3.6% of the total births reported.

Occupancy

The occupancy of hospitals of 100 beds or less was 59.7 per cent. For hospitals of over 100 beds, the occupancy was 78.9 per cent. For the small hospitals, the lowest occupancy was in Manitoba (48.3%), Yukon and N.W. Territories and Quebec; the highest was in Prince Edward Island (66.2%), the other Maritime Provinces and Saskatchewan. For the larger hospitals, the lowest occupancy was in Quebec (76.7%), and the highest was Saskatchewan (83.5%).

Personnel

The total personnel of the 869 hospitals reporting was 38,293. There were 604 more graduate nurses and 567 more pupil nurses than in the previous year. There were 684 salaried doctors, of which 54.9% were on the staffs of general public hospitals. Interns total 761, graduate nurses 7,561, student nurses 9,130 and graduate and student dietitians 409.

The personnel per 100 patients, based on the daily average number of patients was 88.9% for all public hospitals; the number of graduate nurses on the same basis was 17.1 per cent.

There were 194 approved schools for nurses, the average enrolment being 47.1 per cent. There were 21 hospitals with 256 students in unapproved schools of nursing.

Medical Services

There were 261 organized staffs, the number of staff doctors totalling 6,257. Staffs were unorganized in 577 hospitals, of which number 234 were in private hospitals. The number of doctors in attendance at these hospitals was 4,122.

There was an increase of 2.5% over 1935 and of 24.1% over 1933 in the number of organized services. Of the 869 public and private hospitals reporting, 503 had X-ray departments, 309 clinical laboratories and 236 physiotherapy departments under competent supervision. There were 77 organized public out-patient departments.

Admissions

There were 60,208 more admissions to public and private hospitals than in 1935. The total number of patients under care in 1936 showed an increase of 6% over the previous year. The average daily number of patients was 42,616. The total patient days was 15,598,595, an increase of approximately one-half million days.

Average Length of Stay

General Public	14.0%
Infants born in hospital	10.9%
Paediatric	20.2%
Isolation	24.8%

(Continued on page 32)

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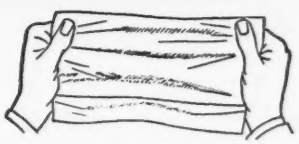

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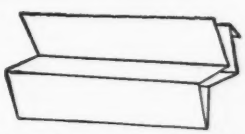

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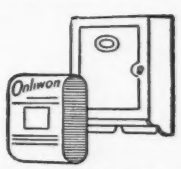

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Interesting New Statistics on Canadian Hospitals

(Continued from page 30)

Convalescent	34.5%
Tuberculosis	120.0%
Incurable	238.2%
Private hospitals	11.8%

Dominion Hospitals

There are 8 hospitals for the treatment of disability pensioners and war veterans. These have 2,620 beds, the number of admissions being 6,483. These have 2,620 beds, the number of admissions being 6,483. There are 555 veterans treated in departmental and other institutions. There are 5 quarantine hospitals, 1 marine and 2 leper hospitals under the National Health section of the D.P. N.H. The Department of Indian Affairs operates 7 hospitals with a total capacity of 203 beds, and the Department of National Defense operates 9 hospitals having 328 beds.

Health Progress in Soviet Russia

Note: The Soviet Union has made remarkable progress in its health program. Whether or not we view with approval the political organization of the U.S.S.R., it is generally admitted that this country has done more than perhaps any other country to advance its organized health care during the past two decades. The following review is condensed from an article by Henry E. Sigerist, M.D., Professor of the History of Medicine at Johns Hopkins University in "Soviet Russia To-day", 1917-1937 Anniversary Number.—Editor.

THE Soviet Union is twenty-years old to-day. A healthy young generation is growing up in the Soviet Union. When you see 100,000 young workers, men and women, marching in splendid physical condition and when you remember that under the old regime these same people would have been brought up in slums, in an atmosphere of filth, alcohol and disease, then you begin to realize what the Revolution has done for the people's health. These results are the more remarkable as the Soviet health authorities had to begin their work under most devastating conditions. Eight years of imperialist war, civil war and foreign intervention had resulted in famine and terrific epidemics which had played havoc with the people's health.

From 1913 to 1936 the general death rate dropped from 30.2 to 11.2 for every 1,000 population; infant mortality was reduced by more than 50 per cent, from 24 per cent in Tsarist Russia to 11.8 in the USSR and in White Russia even to 8.8. The death rate from pulmonary tuberculosis—still a serious problem in the USSR—was reduced by one-half. Great progress was made in combating venereal diseases. The incidence of primary syphilis decreased from 25.7 per 10,000 population to 1.8 in cities, and from 2.66 to 0.62 in villages. Prostitution has practically disappeared. As a result of systematic immunization of the population the morbidity of diphtheria dropped from 34.5 for every 10,000 in 1913 to 6.3 in 1935 and smallpox is disappearing rapidly. Cholera, a dreaded scourge in Tsarist days, has been entirely overcome since 1927. Trachoma, a contagious eye disease that was very widespread among the national minorities and was responsible for thousands of cases of blindness, decreased considerably in the Chuvash Autonomous Republic—to give one example—from almost 80 per cent of the population to 47 in 1926 and 17 in 1936. Industrial accidents were reduced by one-half during the period of the first Five-Year Plan alone and the figures of the second Five-Year Plan will show a further considerable reduction.

Medical service is financed on public funds and for the wage-earning population partly on social insurance funds. Every wage earner is insured, and the premiums are paid by the enterprises. All physicians are in the service of the state. They are paid salaries so that money considerations do not interfere in the relationship between physician and patient. Like engineers they are among the best paid Soviet workers and enjoy all benefits of social insurance such as vacations on full pay and old age pensions. Their working day has been set at six hours and for certain specialties (psychiatry, tuberculosis, X-ray) at even less. Every three years they may attend post-graduate courses of from 3 to 4 months without any expenses involved. Not only is medical education free, but the great majority of all students are paid stipends.

The number of physicians was utterly inadequate in Tsarist days. In twenty years it has been increased from less than 20,000 to more than 100,000. There still is a shortage of physicians but it is becoming less every year. The number of medical schools was increased from 13 to 51.

In the Soviet Union all medical activities, preventive and curative, medical education and the medical industries are controlled by central bodies, the People's Commissariats of Public Health of which there are eleven, as many as constituent republics. Where such centralized direction exists, the protection of the people's health can be organized in the most rational and logical way. The entire Soviet system of public health is built upon the idea of prevention.

The service begins with the pregnant woman who in the Women's Consultation Bureau is examined at regular intervals and from which she is referred to a Maternity Home for confinement. The number of maternity beds was increased from 4,709 in 1914 to 48,250 in 1936 and

(Continued on page 34)

Cut out this page and keep for reference.

COLGATE'S CLEANLINESS CHART

REDUCE SOAP COSTS INCREASE CLEANING EFFICIENCY

AUTOMOBILES	I
BATHING—HAND WASHING	
Patients	A-B
Doctors	A-B
Staff	A-B
Mechanics	C
Washrooms	D
BEDS—CHAIRS—FURNITURE	
Enamel	G-I
Metal	G-I
Finished Wood	G-I
BLINDS	
Shades	G-I
Windows	G-I
Venetian	G-I
CHINA, CROCKERY	
By Hand	I-J
FLOORS	
Cement (treated or untreated)	J
Cork	G-I
Linoleum (all kinds)	G-I
Marble	J
Mastic	I
Painted	H-J
Rubber	G-I
Terrazzo	H-J
Tile	G-I
Wood	
Plain	H-J
Oiled	H-I
Varnished	H-I
Waxed	H-I
KITCHEN	
Containers	
Food	J
Refuse	J
Dishes (cooking utensils)	
Pots—Pans—Kettles	
Aluminum	J
Copper	J
Enamelled	J
Refrigerator Cabinets	
Enamelled or Varnished	I
Metal	J
Plastic, Bakelite, etc.	J
Trays	J
Steam Tables, Metal Chests	
Copper	C-J
Plated	C-J
Stainless	C-J
Trucks—Carts—Metal	
Enamelled or Painted	I
Stainless	J
Machines	
Mixers, Slicers, Choppers	J
LAUNDERING	
Aprons	E-F
Baby Clothes (cotton)	F
Blankets	F-G
Curtains, Drapes	F-G
Overalls	F-J
Pillows	F-G
Sheets, Pillow Cases	E-F
Silks, real and artificial	F-G
Towels	F
Uniforms	
White	E-F
Coloured	F
Wool and Part Wool	F-G
Woollen Knit Goods	F-G
MARBLE	
Railings	G-I
Statuary	G-I
Walls, etc.	G-I
METALS—PLUMBING FIXTURES	
Enamelled	G-I
Plated	
Chromium	G-I
Nickel	C-J
Silver	C-J
Stainless	C-J
Vitreous Enamel, Vitrified China and Tile	
Fixtures	C-J
Fountains	C-J
Lavatories	C-J
Pools	C-J
Sinks, Tubs	C-J
RUGS	
Write for Special Bulletin	
TRAY SERVICE	
Tableware (Burnishing)	G
Tableware (Cleaning)	J
WALLS	
Composition (Asbestos or Painted)	G-I
Fabrics (Painted)	G-I
Linoleum (all kinds)	G-I
Marble	G-I
Plastic (Painted)	G-I-J
Tile	G-I-J
Wall Paper (Washable)	G-I
WOODWORK	
Trim, Furniture	
Unpainted	G-I
Enamelled	G-I
Lacquered	G-I
Painted	G-I
Varnished	G-I

LEGEND

(1) TOILET SOAPS

A–PALMOLIVE SOAP—a pure natural green toilet soap made from Olive and Palm Oils. It is hard, economical — delicately perfumed and pleasing to use.

B–CASHMERE BOUQUET—Coleo—Assorted Soaps — Caravan Castile and Colgate's Floating. All pure, free-lathering, good toilet soaps.

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D–PALMOLIVE SOAP IN BEAD FORM—for use in Palmolive Dispensers. Also Liquid Toilet Soap.

(2) LAUNDRY SOAPS

E–SPECIAL X CHIPS AND POWDERS—pure soaps for use where high temperatures are used for laundry washing.

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G–TEXOLIVE KWIKSOLV—a pure olive and oleic granulated cold water soap for washing blankets, woollens, curtains, drapes, pure and artificial silks and all types of fine fabrics.

(3) CLEANING SOAPS

H–ELEPHANT BRAND — 8 oz. and 16 oz. bars. Pure soap for general cleaning. Contains no heavy fillers to make weight, no excess moisture.

I–TEXOLIVE — 16 oz. bars. Pure olive and oleic soap. Unsurpassed for washing linoleum, blinds, furniture, automobiles, etc.

J–SOILOUT POWDER — a blend of easily dissolved soap and cleaning agents. Used on first ten minute operation in laundry at 100° F., it will take 80% of soil out of the clothes. Formulas for its use with pure soap supplied. Also useful as a mopping powder and for metal and porcelain cleaning.

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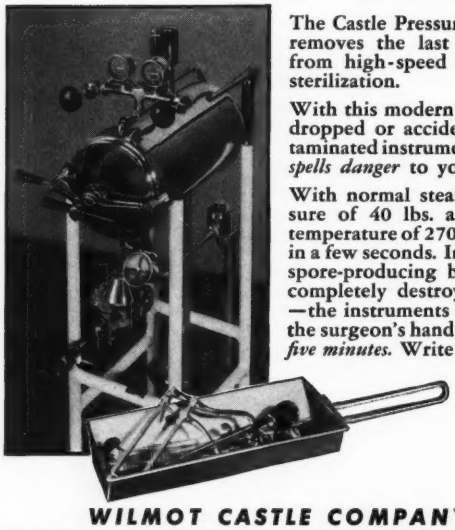

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Health Progress in Soviet Russia

(Continued from page 32)

funds have been appropriated to establish 11,000 more beds in cities and 32,000 in rural districts by January 1, 1939. Two months before and two months after delivery the Soviet woman is free from work on full wages. When a child is born the woman brings him to the Children's Consultation Bureau where his physical and mental development is permanently watched. If a mother is unable to nurse her child she may obtain milk from the Breast Milk Station. Once the child is weaned the Milk Kitchen supplies the kind of milk prescribed by the doctors.

When the mother returns to work the nursery takes care of the child during her working hours. While in the nursery the child is under constant medical supervision, which does not relax when after three years the child joins a kindergarten and later at the age of seven or eight enters school. The Children's Consultation Bureaus protect the health of all those children who are not in such institutions. School physicians are responsible for the health of school children.

And finally, when the young men and women leave school and begin to work, in factories, farms, offices or wherever it may be, they find either in their residential districts or right in the working places Health Centres whose function it is to protect their health. These health centres are called dispensaries, polyclinics, ambulatoria, preventoria or prophylactoria. They consist of a group of physicians of various specialties and auxiliary personnel. They give both preventive and curative service. All workers are given entrance examinations and in harmful industries periodic examinations are required. The health centre of a factory supervises the sanitary conditions of the plant, the labor conditions and the kitchens. The Soviet Union has developed a system of collective feeding that embraces many millions of workers.

As the health centre of a factory has records of the physical condition of all the workers employed, it knows which individuals require special protection. It sees to it that tubercular workers may perform light work and receive special diet. Many centres have a Night Sanatorium, an institution created by the Soviets, in which people who are well enough to remain at work, yet require special care and treatment, spend the night for a number of weeks under medical supervision. Some centres are directly connected with hospitals, others refer their patients to hospitals in the vicinity. The number of hospital beds was increased from 175,600 in 1913 to over 500,000 in 1937.

Workers, who without being sick are in want of a rest under medical control, spend their vacations in Rest Homes. More than 100,000 beds were available in such homes in 1937 accommodating over 2 million people. Chronic patients are sent to Health Resorts for treatment at the expense of the social insurance funds, the trade unions or other agencies.

In 1935, 480 health resorts were in operation, and over a million chronic patients spent periods of from four to six weeks in such places this year and received the treatment that their condition required.

It is obviously impossible to carry out such an ambitious program without the active co-operation of the population. In the Soviet Union every factory and farm, every work-

ing place has its health committee or health nucleus which performs a tremendous amount of volunteer work in close co-operation with the medical agencies. The committees control the hygienic conditions of the plant, the social services, nurseries, kindergartens. They organize health lectures and exhibits and are the most valuable allies of the medical corps.

Research is planned like any other Soviet activity, and in the medical field the Medical Scientific Council is the guiding and co-ordinating agency, a body consisting of about 120 outstanding medical scientists. A great deal of research is required to forge the weapons to fight disease. The Russian Commissariat of Public Health controls no fewer than 34 central research institutes with more than 150 affiliated local institutes, employing altogether about 8,000 scientific workers. Other institutes are connected with local health departments and trade unions. The medical research centre however is the Maxim Gorky All-Union Institute of Experimental Medicine in Moscow. It already has a staff of 600 scientists and is one of the largest institutes in the world. At present a new plant is being built, a regular city of science, and in a few years this institute will be a perfectly unique institution with boundless possibilities for medical research.

Book Review

A Text-Book of Pathology. *Wm. Boyd, M.D., LL.D., M.R.C.P. Ed., F.R.C.P., Lond., F.R.S.C., Professor of Pathology, University of Toronto.* Third edition, 1064 pp., illustrated, 459 engravings and 16 col. plates. $10. Lea and Febiger, Philadelphia, 1938.

This well-known and popular work on pathology has undergone extensive revision in this third edition. The more recent studies in pathology and in pathological physiology have been reviewed, a new section on sudden death has been added, the anemias and the pneumonias have been re-classified and the section on viruses has been re-written. A number of new color plates and other illustrations have been added. By the judicious use of smaller type, much new material has been possible without enlargement of the book.

Professor Boyd's work is essentially practical and designed for the student and practitioner. It is a volume which could well be added to the hospital medical library, to the school for nurses reference library and to the library of every medical staff member.

Films on Surgery

In the April issue attention was called to the availability of educational films for the use of hospitals and their staffs. It has been called to our attention that there should be added to that list the library of surgical motion pictures prepared by Davis & Geck, Inc. These are available through Ingram & Bell, Limited, and are stocked in Canada, thus facilitating bookings and shipments without the difficulty incidental to customs clearance. The list of 16 mm. films is revised annually, the series catalogued being available on request. These films are available without charge to hospitals and medical schools.

VITAMIN B_1
FOR
IMPROVED INTESTINAL TONE

Because recent studies have shown that vitamin B_1 has a beneficial effect on the tone of the intestines, this vitamin is receiving more and more attention as an aid in treating atonic constipation.

A good source of vitamin B_1 is Kellogg's All-Bran. Notice below how the vitamin B_1 content of All-Bran compares with that of other foods.

The presence of this vitamin, in such plentiful quantities, in a food which also contains natural "bulk," is being recognized as a further reason for recommending this laxative cereal.

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A Natural Laxative Cereal

Ontario Hospital Association News

ON April 18th, the first sod was turned for the start of construction of a $250,000 pavilion at the Mountain Sanatorium, Hamilton. The new unit will stand as a striking monument to the philanthropy of Charles S. Wilcox, retired industrialist of that city.

Good progress is being made in the construction of the new mental hospital at St. Thomas, which when completed will not only be one of the largest in Canada, but one of the finest on the North American Continent. In all there will be some 35 distinct units, comprising several buildings.

An application to Toronto City Council for a contribution towards the cost of the proposed $300,000 addition to the Toronto East General Hospital will be made at an early date, it was indicated at a joint meeting of the Toronto East Medical Association and the Board of Governors of the hospital on April 21st.

On April 22nd, a decision was made by the York Township Medical Association to seek government approval for the erection of a publicly owned hospital within the township.

Fire in a wastepaper chute in the old building at the St. Joseph's Hospital, Sudbury, caused excitement among the Sisters, patients and nurses on April 8th, when smoke poured up through three floors from a blaze in the basement. No damage was done to the hospital.

The Hotel Dieu, Windsor, is asking for a civic grant of $25,000 to help finance completion of the new addition to the hospital.

The remarkable strides made by medicine and surgery was shown in vivid detail by motion pictures at the district meeting of Hastings and Prince Edward Medical Society held at Belleville General Hospital recently.

On April 5th, $5,000 was granted by the County Council to Norfolk General Hospital to purchase needed equipment for the new wing.

Returns from a successful theatre night on April 6th, enabled the Moose Lodge at Port Hope to purchase and present an oxygen tent to the Port Hope Hospital.

Dr. E. T. Kellam, a member of the Niagara Falls Hospital Trust for the past 25 years, was appointed secretary-treasurer of that organization on April 12th. He succeeds Mr. Robert M. Gay who resigned a month ago.

Mr. E. R. Purtle succeeded Mr. W. J. Motz as chairman of the St. Mary's Hospital Board, Kitchener, on April 6th.

As a result of requests from the London Trades and Labor Council, night orderlies at Victoria Hospital, London, are going to get a six-day week.

Dr. Wilfred D. Smith, senior assistant physician in the Department of Health, will be the medical superintendent of the new mental hospital under construction in Elgin County, it is reported.

Construction of the large addition proposed for Fort William Sanitorium at a cost of about $135,000 will probably get under way early in May, it is stated by officials of the Sanatorium Association.

The property committee of the Public General Hospital Board, Chatham, has been authorized to proceed with drawing up detailed plans and specifications for the proposed new $100,000 wing which it is hoped to build this year.

The new Nurses' Residence and hospital wing of St. Mary's Hospital, Timmins, recently erected at a cost of $130,000, were officially opened on March 26th.

* * *

WOMEN'S HOSPITAL AIDS ASSOCIATION
Province of Ontario, Canada

Association formed 1910 *Individual Aid formed 1865*

Association formed 1910 Individual Aid formed 1865

"When you lack interest in the case, the job will very likely lack skill and diligence in performance."—Lincoln.

The Women's Sinais Aid to the Mount Sinai Hospital, Toronto, gave $2,500 to the hospital recently. This contribution is the proceeds of a Valentine party given by this energetic group comprising sixty-eight members.

There are five distinct hospital aids doing splendid work for the Mount Sinai Hospital: The Mount Sinai Auxiliary, The Mount Sinai Medical Auxiliary, The Mount Sinai Dental Auxiliary, The Sinais, The Twigs Auxiliary.

The Groves Memorial Hospital Aid of Fergus gave $654.75 to the hospital; installed a dryer in the X-ray room, purchased four hospital beds with mattresses complete, also dishes and silverware. This aid has two hundred and seventy-nine members. Their sewing groups during the year are active, having mended 1,574 articles, made 548 articles, also looked after the marking of all the required articles in the hospital.

The Women's Hospital Aid to the General Hospital, Guelph, with a membership of thirty-five, purchased gatch beds and bedside tables. Four hundred and eighty-four dollars and thirty-four cents was given to the hospital.

The Senior Aid to the Brantford General Hospital purchased one obstetrical table, one electric floor polisher and one electrolux; redecorated sitting room in nurses residence; gave fifty dollar scholarship to graduating nurse; besides the active sewing groups, making sheets, slips, bags, towels, binders, bandages, gowns, shrouds and masks, pneumonia jackets and operating room socks, etc., etc. The tea-room conducted for the convenience of hospital patrons served two thousand and thirty-eight lunches during last year, and served 22,060 customers during the year. The Junior Hospital Aid to the Brantford General Hospital do a very excellent work in providing all the requirements for nursery.

The Women's Hospital Aid to St. Peter's Infirmary, Hamilton, provide games, delicacies such as (home-made jams, fresh fruit, candy), also flowers, reading matter, eye-glasses, artificial teeth, and installed three electric clocks, gave twenty-five dollars worth of tulip bulbs for

planting and provide all materials used by the occupational therapist.

The Women's Hospital Aid to the St. Joseph's Hospital, Chatham, besides the general activities made over a thousand articles in their sewing room and gave a silver spoon to every baby born in the hospital. Last year this aid gave fourteen hundred dollars to the hospital.

The Heather Club Auxiliary to the Chatham General Hospital furnished two private rooms. The members are very active in their sewing groups and have given the hospital multi-beam lamp, water softening plant, diathermy, obstetrical tables, operating room lights, operating room tables, furnished living-room in nurses residence, also the sun-parlours; also purchased the electric stoves for the hospital. This Aid gave a passenger and freight elevator to the hospital.

The Chatham General Hospital has four active hospital aids all doing necessary and commendable work.

The St. Joseph's Hospital Auxiliary, London, gave four scholarships; decorated the main entrance and also the nursery; erected cubicles in women's ward; conducted a successful fruit shower; gave nearly one thousand dollars to the hospital. Much sewing was accomplished by the groups. The samaritan cupboard meets a great need in supplying necessary wants for indigent patients.

The Cradle Club Aid to St. Joseph's Hospital, London, purchased Victrola and records, awnings, garden swing, books and toys for the children's wing; re-decorated several rooms in the children's department. A hundred and thirty-two bibs; one hundred and twenty-eight nighties, sixty-two sheets and seventy-eight pillow cases were made for the children's wing.

The Mount Forest Women's Hospital Auxiliary purchased bedroom suite and other furniture for the superintendent's bedroom. Held a successful shower when four hundred and forty-three jars of jelly, fruit, pickles, honey and vegetables were given to the hospital. Linens and dishes were purchased.

Sales Tax Exemption Applicable When a Rural Hospital Purchases from a Departmental Store

The question has been asked, "Is a hospital entitled to sales tax exemption on purchases from a departmental store by mail?" The Commissioner of Excise has replied in the affirmative.

If a rural hospital, certified under the provisions of Circular 707-C as a bona fide public hospital, makes purchases from a departmental store, the procedure in such cases is that an authorized official of the hospital signs the usual form of certificate on an order form which he transmits to the departmental store. The store is thus authorized to obtain a refund of the sales tax, which it paid on its purchases of the goods in question, and it usually passes this credit on to the hospital directly and then makes application to the Commissioner of Excise for a refund of the tax. The Excise Department is receiving refund claims continually on this account, not only from departmental stores, but independent retailers and unlicensed wholesalers as well.

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Here and There in the Hospital Field

By THE EDITOR

ALBANY, N.Y.—Governor Lehman has vetoed a bill providing surgical, medical and hospital care for needy victims of infantile paralysis, the cost to be divided equally betwen the state and the county. It was opposed by Mayor LaGuardia of New York City on the grounds that any such program should be determined by the city itself, and that the bill destroys the separation of preventive from therapeutic health work.

Presumably the Governor had sufficient reason for his action, but those of us who have observed for many years the highly beneficent results of provincial and municipal support of hospital care for indigents, and have noted the gradual extension of medical relief, as developed in this country, cannot but feel that the principle at least of this measure would seem sound.

* * *

TENNESSEE.—A few weeks ago, while travelling through the Great Smoky Mountains in eastern Tennessee, your scribe had an opportunity of hearing first-hand the tales of the mountaineers in that picturesque but isolated area. Said one small hospital administrator, "Our doctah has been pryin' lead outa folks' hides fo' nigh on fo'ty yeahs an' Ah'll be doggone if he didn't gouge out a .38 this week! Why, no self-respectin' mountaineer from these heah parts would use anythin' less than a fo'ty-five!"

* * *

LONDON, ONT.—That hospital records were a farce and were compiled by some 16 or 17 year old girl studying to be a nurse were alleged to be among the criticisms levelled at the Victoria Hospital, London, by a London lawyer participating in a recent Supreme Court trial. Unfortunately, these criticisms received wide press publicity. These charges were resented very much by the trustees and staff of the hospital, and at a joint meeting of the Trust and the Medical Advisory Board a strong statement of denial of the insinuations was passed and made public. Criticism by the lawyer of public ward care was vigorously refuted.

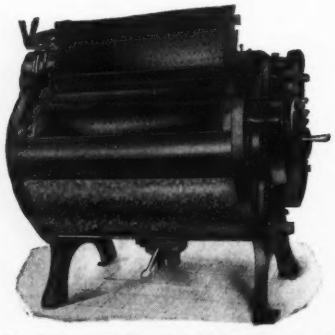
LOS ANGELES.—Just when the really progressive surgeon has begun to realize that he must needs arm an assistant with a movie camera to record candid shots of his surgical skill and prowess for display at the next clinical meeting, along comes a new headache. A California doctor has been sued by a woman for $75,000 for taking motion pictures of her during an operation without her consent. It is presumed that they were taken purely for scientific purposes, and it is doubtful if the plaintiff could even recognize her own picture; nevertheless, such suits are annoying to the defendant, and it is amazing how rapidly one case can make a whole community or even continent forensically-minded.

* * *

MONTREAL, QUE.—The Royal Victoria Hospital was cleared of charges of negligence in a Superior Court decision, in a case where the hospital was sued for negligence in connection with a death under anaesthesia. It was claimed that the hospital had not used proper care in the administration of the anaesthetic, the hospital and the doctor being sued for $1,000 expenses and $19,000 for loss of support. His Lordship found that death may have been caused by embolism, operative shock or a complication arising from the anaesthetic. Even if due to the anaesthetic, there was no proof that any professional shortcomings on the part of the doctor or the nurse were to blame.

* * *

SCARBORO, ONT.—Some 350 Scarboro Collegiate students were given tuberculin tests and about 40 per cent gave a positive reaction, although none were found to be active. The health officer was well pleased with the report. However, the findings caused grave alarm in parts of the county, as parents were well acquainted with the fact that cows giving a positive tuberculin reaction are supposed to be slaughtered!



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KAMLOOPS, B.C.—Six years ago the Royal Inland Hospital was faced with bankruptcy when it had a load of liabilities amounting to $39,000. To-day it is free of all obligations. At the end of 1937 the hospital's liabilities were $5,779; assured revenues and inventories were valued at $16,830. Many repairs and replacements have been made. The development of a hospital insurance plan has been largely credited with this change. There are over 2,100 heads of families or single persons insured.

* * *

TORONTO, ONT.—Under the auspices of the Big Sister Association, the blooms, that provided such a colorful and magnificent spectacle of floral beauty at the National Flower and Garden Show recently held for the first time in Canada, were distributed to the local hospitals, thus giving keen enjoyment to many not privileged to attend this mammoth exhibition.

* * *

WOODSTOCK, ONT.—Less than 8% of drug addicts owe their addiction to medical reasons according to Doctor D. O. Lynch, superintendent of the local Ontario Hospital. In other words, about 92% of the 9,000 drug addicts in Canada owe their trouble to vice, vicious environment and criminal association. Some addicts have stated that illustrated articles and magazines led them to experiment with the drugs on themselves. A study of addicts showed that only 14% were liquor users. Doctor Lynch anticipated that before long hospital facilities for the care of drug addicts would be provided.

Canadian Tuberculosis Association to Meet in London

The Canadian Tuberculosis Association will hold its annual convention in London, Ontario, on Thursday and Friday, June the 9th and 10th. It will meet jointly with the Michigan Trudeau Society and the Ontario Laennec Society. Headquarters will be at the Queen's Hotel.

Hospital Superintendent Wanted

Applications are invited for the post of Superintendent of a General Hospital of one hundred bed capacity of the Province of Ontario. Apply with references, stating experience and salary expected to Box 203-0, The Canadian Hospital, 177 Jarvis St., Toronto.

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News of Hospitals and Staffs

James Rodgers Called

We regret to report the sudden death on March the 29th of Mr. James Rodgers of Drumheller, Alberta, immediate past-president of the Alberta Hospital Association and secretary-treasurer of the Drumheller Municipal Hospital.

Early in the year Mr. Rodgers had a severe cranial concussion following an accident, and had not fully regained his health. Only a few days before his sudden death, he had tendered his resignation as secretary of the local hospital. He was a war veteran.

Mr. Rodgers was an ardent supporter of organized hospital work, and did much to further the development of better hospital care, not only in his own community but throughout his province. His colleagues in the hospital field will greatly miss his valuable co-operation and assistance.

Fredericton Hospital Seeks Legislation

Victoria Public Hospital at Fredericton, N.B., has obtained the approval of the House Committee to its amended Bill, which would permit Fredericton and other municipalities to contribute financial support for the new addition. The City Council of Fredericton is supporting the measure, which requires a strong majority in the Council before the obligation becomes operative and provides certain financial protection to the city. There is no question but that the new addition is badly needed, as many of the beds are now in an obsolete wooden building, which should be replaced. The proposed expenditure for the new addition would seem very reasonable in view of the facilities to be obtained. The surrounding communities concerned, however, are not unanimous on the question of providing the necessary funds for the new construction.

Radiologist at Sydney and Glace Bay

Doctor H. R. Corbett, formerly of Kentville Sanatorium, has taken up his duties as joint radiologist for St. Rita's Hospital, Sydney, Sydney City Hospital and St. Joseph's Hospital, Glace Bay, following a period of post-graduate work in the States.

Radiologist at Collingwood

Doctor G. S. French, Radiologist of the Owen Sound General and Marine Hospital, has been named Radiologist to the General and Marine Hospital at Collingwood. He has recently been elected a member of the British Association of Radiologists.

Canadian Hospital Council Has Busy Year

In 1937 the C.H.C. dispatched 4,558 pieces of mail. While many of these were of a routine nature, a large proportion represented individual studies, some requiring many hours of work.

Senator White Bequeaths $10,000 to Montreal General Hospital

Receipt of a cheque for $10,000, a cash legacy bequeathed by the late Senator Smeaton White to the Montreal General Hospital, was recently announced.

Senator White, prior to his death over a year ago, was a governor of the hospital for more than 30 years and was also an active member of the board of management from 1916 to 1928, when he was elected to the advisory board of the institution.

Construction

The Ontario Government has made a $50,000 grant to St. Peter's Infirmary in Hamilton. This fund, with the addition of a large amount being raised in Hamilton, will be used for the construction of a new wing.

* * *

The Quebec Government will guarantee, up to $750,000, the amount of any loan contracted, by means of bonds or otherwise, by the Verdun Protestant Hospital for the purpose of enlarging the building. A recent survey by the Rockefeller Foundation had revealed that there was 43% overcrowding in this building.

* * *

Stevenson Memorial Hospital, Alliston, Ontario, plans the construction of a nurses' residence to cost approximately $20,000. Gordon Adamson, architect, is preparing plans.

* * *

An 8-bed nursing home is to be erected at Peesane, Sask. Each family in the community is expected to donate to the value of $12 in lumber or cordwood. The settlers in Block D have already donated 7,000 feet of lumber. The labour on the building is to be done as a relief project.

* * *

Two $30,000 hospitals will be built in Alberta, one in Olds and one in Didsbury. Separate agreements were drawn up for each hospital at a joint meeting with the interested Councils, the chief conditions of each being that a $30,000 hospital be built in each town, with one-third of the cost to be carried by the towns, and one-third of the cost to each hospital to be carried by the two rural municipalities. Expenses of operation were to be divided in the same manner.

* * *

Plans for a new three-storey nurses' residence at St. Mary's Hospital, Montreal, are being prepared. The new building will release about 50 beds in the hospital.

* * *

Structural completion of three unfinished floors of the private patients' pavilion, Montreal General Hospital, Western Division, is under consideration by the hospital building committee.

* * *

Erection of a 100-bed addition to the New Waterford General Hospital, N.S., is proposed.

* * *

Construction began early in April on the new hospital to be established at Flin Flon, Manitoba, by the Grey Nuns from St. Hyacinthe, Quebec.

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Mr. L. A. Young Given High Post in Stewart-Warner Organization

The appointment of Mr. L. Arthur Young to the position of Vice-President and General Manager of the Stewart-Warner-Alemite Corporation of Canada Limited, in succession to the late Mr. W. E. Rowsome, who held this position for many years, has been announced.

Mr. L. A. Young.

Born in Belleville, Arthur Young "grew up" with the Stewart-Warner-Alemite Corporation of Canada Limited, having been associated with the firm since its inception.

Mr. Young joined the original Canadian Company, Alemite Products of Canada, shortly after the war. Thus he has seen the introduction into Canada of the manufacture of Alemite Products, Stewart-Warner Radios (1929), Bassick Casters (1931), South-Wind Car Heaters (1937) and many other Stewart-Warner-Alemite lines.

Ste. Justine Hospital Delegation Request Provincial Grant for Construction of New Wing

Ste Justine Hospital, represented by a strong delegation including Madame L.-de-G. Beaubien, President of the Administrative Council of the institution and Messieur Paul Lacoste, who drew up the brief, presented a request to the City Council of Montreal for an annual grant of $50,000 for a period of 25 years, in order to permit construction of a much needed wing and to meet the expenses incidental to the hospital debt.

Modern Scrubbing and Waxing Equipment in the Hospital

To-day, a large number of Hospitals throughout Canada have dispensed with the tiring and unsatisfactory method of scrubbing-waxing-and polishing floors by hand. They now use electrical equipment which does all of the three jobs mentioned in much less time than it would by hand, and which gives a more satisfactory appearance, and more protection to the floors.

The "Finnell" Electric Scrubbing-Waxing-Polishing Machine is a favourite in the Hospital. The unique "Kote Dispenser" on the Finnell Machine saves many hours of labor on bended knees applying wax to a floor. The wax, liquid or paste, is put into the Kote Dispenser which heats the wax—if paste, to a liquid form—and this hot wax is distributed to the floor through a valve which is controlled by the operator. The floor is then ready for polishing.

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Col. D. E. MacIntyre Opens New Business in Owen Sound

Col. D. E. MacIntyre, well known to the hotel, hospital and restaurant trade as General Manager of The North American Furniture Co. and Owen Sound Chair Co., of Owen Sound, which companies closed operations some five years ago, announces the opening of business under the name of Howe Folding Furniture Co. of Canada, in Owen Sound.

Col. D. E. MacIntyre.

This Company will make and distribute in Canada and export to many parts of the British Empire, folding furniture specially designed for hotel, hospital, restaurant, clubs, churches, lodges, camps, and such places.

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